

HEALTH HISTORY INFORMATION

Name: _____ Date: _____

MEDICAL HISTORY

Name of Physician _____ Phone: _____

-Are you currently under the care of a physician? Yes/No

Date of last physical? _____

-Have there been any changes in your general health or have you been hospitalized in the last year? Yes/No

If your answer is yes, please explain: _____

-Do you have any allergies or sensitivities? Yes/No

If your answer is yes, please list: _____

-Are you taking any medications? Yes/No

Prescription / Over the Counter / Herbal? / Natural? Yes/No

If yes, please list: _____

Please circle any of the following conditions you have or had in the past:

Abnormal/Prolonged Bleeding/Blood Disorder

Alcohol/Drug Abuse? Treatment

Allergies

Anemia

Arthritis / Rheumatism

Artificial Joint Replacement

Asthma

Bruise Easily

Cancer

Radiation or Chemo-Therapy

Cold Sores (Herpes)

Diabetes --Type:

Eating Disorders

Emphysema

Fainting / Epilepsy / Seizures

Glaucoma

Infectious Disease

Tuberculosis (TB)

Hepatitis – Type:

HIV / AIDS

Immune System Disorders

Muscle / Joint / Facial Pain

Neck or Back Pain

Heart Trouble:

Arrhythmias/Palpitation

Artificial Heart Valve

Angina / Chest Pains

Heart Murmur

Heart Attack

Heart Surgery

Pacemaker

Swelling of Ankles

Rheumatic Fever

High Blood Pressure

CVA / Stroke

Scarlet Fever

Nervous Disorders

Psychiatric Treatment

Recreational Drugs

Sexually Transmitted Diseases

Sinus Problems

Thyroid Disease

Ulcers

Kidney Dysfunction / Disease

Liver Disorders

Do you have any disease, medical conditions not listed above? _____

Women Only: Are you now or might be pregnant? Yes/No If yes, what Trimester? _____