Health History Form

Have there been any changes in your general health in the past year? Yes No
Are you under the care of a physician? Yes No
If so, for what are you being treated? _____
Date of last medical examination? _____
Have you had any illness, operation or been hospitalized in the past five years? Yes No
If yes, please explain _____

Circle if you had or do you currently have:

□ Prosthetic(Artificial) heart valve	□ Bruise easily
□ Infective endocarditis/Rheumatic Heart Disease (RHD)	□ Jaundice/hepatitis/liver disease
□ Congential heart disease/defect	□ Infectious mononucleosis
□ Total joint replacement	□ Rheumatoid arthritis
□ High blood pressure or low blood pressure	□ Lupus
□ Chest pain, angina	□ Stomach ulcers/irritable bowel disorder/colitis
□ Stroke/Transient Ischemic Attacks	□ HIV+/AIDS
□ Thyroid trouble	□ Hepatitis
□ Diabetes	□ Contagious diseases
□ Low blood sugar	□ Sexually transmitted diseases
□ Kidney trouble/dialysis	□ Immune system problems
□ Heart attack	□ Delay in healing
□ Irregular heart beat	□ Tumor or growth, breast surgery of any type
□ Cardiac pacemaker/implanted defibrillator	□ X-ray treatment or chemotherapy/cancer
□ Heart surgery/ bypass surgery	□ Chronic fatigue
□ Bronchitis/chronic cough	□ Do you smoke? yes no
□ Asthma	□ History of substance abuse/drug use (cocaine,etc.)
□ Hay fever/sinus problems	□ Malignant hyperthermia
□ Tuberculosis	□ Eye disease/glaucoma
□ Emphysema/COPD	□ Mental health problems
□ Difficulty breathing or other lung trouble	□ Pain and/or clicking of jaw when eating/TMD/ TMJ
□ Blood transfusion	□ Convulsions/epilepsy
□ Blood disorders such as anemia/bleeding disorder	

Do you have any other health problems not listed above? Yes No

_____

Medications: Please list all medicine, drugs, pills, and over-the-counter medications you are currently taking:

_____

_____

Important - Circle if you take: Warfarin, Coumadin, Emsam, Aspirin, NSAIDs, Strattera, Viagra, Cialis, Levitra
Circle any herbal medicines you are taking: Echinacea, Ephedra, Garlic, Ginkgo, Ginseng, Kava, St. John's wort, Valerian

Do you have any adverse reactions to any of the following:

□ Local anesthetics (novocaine, adrenalin)	□ Codeine or other narcotics
□ Penicillin	□ Other medications
□ Other antibiotics	□ Latex
□ Aspirin	□ Please list any allergies other than drugs

Women:

Are you pregnant? If yes, estimated delivery date: _____ Yes No
Is there a possibility of pregnancy? Yes No
Are you nursing? Yes No
Please note that any antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Patient Signature: _____ **Date:** _____
Parent or Guardian Signature: _____ **Date:** _____
Doctor Signature: _____