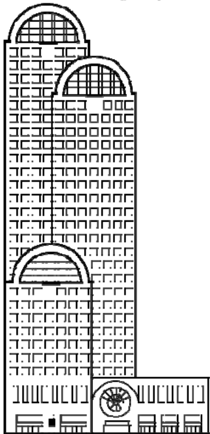

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HEALTH HISTORY

Patient Name ____ Date ________________________

Physician's Name / Phone Number ______________________________ Date of last visit _______________

Do you have or have you ever had any of the following conditions listed below – please check any that apply

- ❒ Diabetes
- ❒ Thyroid problems
- ❒ Autoimmune disorder
- ❒ Shortness of breath
- ❒ Asthma
- ❒ COPD (emphysema, bronchitis)
- ❒ TB
- ❒ Stroke
- ❒ Heart murmur
- ❒ Rheumatic fever
- ❒ High blood pressure ____________
- ❒ Angina / chest pain
- ❒ Pacemaker / defibrillator
- ❒ Heart attack
- ❒ Other heart / circulatory problems
- ❒ Bleeding disorder / abnormal bleeding
- ❒ Blood transfusions
- ❒ Renal/ kidney problems /dialysis
- ❒ Gastrointestinal problems / ulcers / reflux
- ❒ Liver problems / jaundice
- ❒ Hepatitis Type ________
- ❒ Cancer (surgery / radiation/ chemotherapy)
- ❒ Skin problems
- ❒ Joint replacement
- ❒ Muscle / bone problems
- ❒ Bisphosphanate use
  (Fosamax, Boniva, Actonel, Aridia, Zometa)
- ❒ Headaches
- ❒ Jaw pain
- ❒ Neurologic / neuromuscular disorder
- ❒ Nervous problems / depression
- ❒ STD / HIV / AIDS
- ❒ Eye conditions
- ❒ Sleep apnea
- ❒ Snoring
- ❒ Trauma
- ❒ Smoking – how much __________
- ❒ Alcohol – how many drinks per week______
- ❒ Recreational drug use

Women: Are you pregnant? ☐ Y ☐ N Due Date: ____________________ Are you nursing? ☐ Y ☐ N

MEDICATIONS	ALLERGIES	SURGERIES/HOSPITALIZATIONS

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04/29/10