HEALTH HISTORY

Name_____ Date _____

Age _____ Birthday _____

I. What is the reason for your visit? _____

_____

A. History of Illness

1. How long has the condition been present? _____
2. Which body area(s) are affected? _____
3. Have you had this condition previously? _____
4. Does your condition cause you symptoms? _____
   If no symptoms proceed to section B.
5. Please describe your symptoms (pain, burning, itching, stabbing, puffiness, etc.) _____

   _____
6. What makes your symptoms better? _____
7. What makes your symptoms worse? _____

B. System Review

1. Is the condition causing weight loss, fever or affecting your general health? _____
   If yes, please explain: _____

   _____
2. Please circle any of the following body areas if they are affected by the condition.
   Eyes - ears - nose - mouth - throat - muscles - joints.
3. Has the condition caused any enlarged lymph nodes? _____

C. Family History

1. Do any family members have the same or similar condition? _____
2. Which family members? _____

   _____

II. Past Medical History

A. Allergies

1. Please list any allergies to medications: _____
2. Are you allergic to latex? Yes or No
3. Do you have any allergies to anesthetics? Yes or No

B. Please list any chronic medical conditions? _____

_____

C. Please list any surgeries: _____

_____

D. Please circle any of the following conditions with which you have ever been diagnosed.

Asthma	Gout	Lupus
Crohns Disease	Hyperthyroidism (overactive thyroid)	Rheumatoid Arthritis
Cushings Disease	Hypothyroidism (underactive thyroid)	Stroke
Emphysema	Heart Attack	Seizures
Elevated Cholesterol	Hypertension	Tuberculosis (TB)
Cancer: Type_____	Inflammatory Bowel Disease	Ulcerative Colitis
Diabetes	Kidney Disease	Ulcers
Depression	Organ Transplant: Type_____	Vascular Disease
Fever Blisters	Liver Disease	

E. Surgical

1. Have you ever been told that you should receive antibiotics prior to teeth cleaning, dental procedures or surgery? Yes or No
2. Do you have any prosthetic (artificial) joints? Yes or No
3. Do you have a history of rheumatic fever or an abnormal heart valve? Yes or No
4. Do you have an artificial heart valve? Yes or No
5. Do you have a pacemaker or defibrillator? Yes or No
6. Do you have a history of hepatitis? Yes or No
7. Do you have a history of AIDS/HIV or immunosuppression? Yes or No
8. Do you have a bleeding disorder? Yes or No
9. Do you take Coumadin (Warfarin)? Yes or No Last Dose_____
10. Do you take aspirin? Yes or No Last Dose_____

F. Dermatologic

1. Have you ever had a skin cancer? Yes or No
   If yes, please circle type: Basal Cell Squamous Cell Melanoma Don't Know
   Location: _____
2. Is there a family history of skin cancer? Yes or No
   Relationship: _____
   Type of skin cancer (Please circle) Basal Cell Squamous Cell Melanoma Don't Know
3. Do you have a history of atopic dermatitis or eczema? Yes or No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date_____