Welcome To Our Office

PATIENT HEALTH HISTORY

Please Print Clearly.

Full Name: _____ ____ _____ Date of Birth: _____
(First) (M.I.) (Last)

Weight: _____ lbs. Occupation: _____

Are you taking ANY kind of medication now? This includes prescription medications, over-the-counter medications (such as aspirin), or herbal medications.
☐ No ☐ Yes. If yes, please complete the form below.

Please list all prescription, over-the-counter, and herbal medications that you are currently taking.

Medication	Dose (e.g. 25mg)	How Often?	Reason for Medication	Date Started	Prescribing Doctor

Please check all that apply to you:

Chest Pain	NO	YES		NO	YES
Palpitations or irregular heartbeat			Fever, chills or night sweats		
Swelling of ankles (edema)			Fatigue, general weakness, decreased energy		
Shortness of breath or wheezing			Recent change in weight		
Persistent Cough			Hoarseness or difficulty speaking		
Poor Appetite			Dry mouth or trouble swallowing		
Nausea, vomiting or heartburn			Sore mouth, bleeding gums, mouth ulcers		
Diarrhea			Snoring		
Constipation			Nasal Congestion		
Urinary infection or blood in your urine			Frequent colds or hay fever		
Frequent need to urinate			Frequent nosebleeds		
Difficulty emptying your bladder			Bruise easily		
Increased thirst			Blurred or double vision		
Skin rash or itching			Loss of vision, eye problems		
Raw skin, skin sores or blisters			Depression or severe mood swings		
Headaches			Nervousness, anxiety or panic attacks		
Tremors or shaking or convulsions			Neck stiffness, neck pain, neck swelling		
Numbness, tingling or “pins & needles”			Joint pains or arthritis		
Memory loss			Difficulty walking		
Fainting or blackouts			Muscle weakness, cramps or pains		
Dizziness, unsteadiness or vertigo			Severe pain of any kind		

Are you allergic to any medications?
☐ No ☐ Yes. If yes please list

Medication Type of Reaction (hives, nausea)

Are you allergic to pollens, dust, foods, etc?
☐ No ☐ Yes. If yes please list

Allergen Type of Reaction (hives, nausea)

Have you ever been diagnosed with a health problem (such as diabetes, high blood pressure, heart disease, stroke, asthma cancer, lupus, etc?)
☐ No ☐ Yes. If yes please list

Have you ever had an operation?
☐ No ☐ Yes. If yes please list surgery and age or date

Have you ever had a bad reaction to local or general anesthesia?
☐ No ☐ Yes. If yes please list reaction and age or date

Has anyone in your family had a bad reaction to local or general anesthesia?
☐ No ☐ Yes. If yes please list reaction and family member

Have you ever been hospitalized for a medical Problem not requiring surgery?
☐ No ☐ Yes. If yes please list reaction and age or date

Are you ever had a serious accident or a head injury with loss of consciousness?
☐ No ☐ Yes. If yes please list injury and date or age.

Does anyone in your family have bleeding or blood clotting problems?
☐ No ☐ Yes. If yes please list problem and who has it.

Are there any medical problems that run in your family such as diabetes, heart disease, or hearing loss?
☐ No ☐ Yes. If yes please list problem and who has it.

Have you ever used tobacco in any form?
☐ No ☐ Yes. If yes please list type and daily amount

Are you exposed to second hand smoke?
☐ No ☐ Yes.

Do you drink alcoholic beverages?
☐ No ☐ Yes. If yes please list

Type and daily amount From (year) To (year)

Have you been exposed to very loud noise repeatedly or for long periods of time?
☐ No ☐ Yes. If yes please list type of noise (construction, machine shop, fire arms, military service rock concerts) and how many years of exposure.

Thank You

Patient Signature: _____ Date: _____

FOR OFFICE USE: Reviewed with patient. _____