

PATIENT HEALTH INFORMATION

Name: _____

Date: _____

- | | | Yes | No |
|---|--|--------------------------|--------------------------|
| 1 | Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Have there been any changes in your general health within the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Date of your last physical exam: _____ | | |
| 4 | Physician's name: _____ | | |
| 5 | Are you now under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 | Have you ever been hospitalized for any surgical operation or serious illness? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | Yes | No |
|---|--|--------------------------|--------------------------|
| 1 | Do you bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Have you ever required a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Have you had a recent weight loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Have you ever taken Fen-Phen or Redux? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 | Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 | Do you have any disease, condition or problem not listed above that you think I should know about? | <input type="checkbox"/> | <input type="checkbox"/> |

Please Explain: _____

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| 7 | Are you taking any medicine(s)? Including non-prescription medicine. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 | If yes, what medicine(s) are you taking? _____ | | |
| 9 | Have you had any abnormal bleeding? | <input type="checkbox"/> | <input type="checkbox"/> |

Women Only:

- | | | |
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| Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

Are you allergic to or have you had reactions to:

- | | Yes | No |
|---|--------------------------|--------------------------|
| Local anesthetics like novocaine, lidocaine | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates, sedatives or sleeping pills | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Any metals (e.g., nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex / rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list) _____ | | |

- | | Yes | No |
|------------------------------|--------------------------|--------------------------|
| Hives or skin rash | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Aids or HIV infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis or rheumatism | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint replacement or implant | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach ulcer | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have or have you ever had the following:

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|--|--------------------------|--------------------------|
| Rheumatic heart disease or rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart defect or heart murmur, mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart trouble, heart attack or angina | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| High/low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart problem | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling of feet, ankles, hands | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> , jaundice or liver disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung, breathing problems or asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Lupus (SLR) | <input type="checkbox"/> | <input type="checkbox"/> |

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| Cough that produces blood | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy or radiation | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy or seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervousness | <input type="checkbox"/> | <input type="checkbox"/> |
| Tumors | <input type="checkbox"/> | <input type="checkbox"/> |
| Back problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemical dependency | <input type="checkbox"/> | <input type="checkbox"/> |
| Steroid treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold sores/fever blisters | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Any disease or condition not listed above | | |