Health History Form

MEDICAL INFORMATION:

Primary Health Clinic_____

Primary Physician_____

Date of Last Exam_____

Are you currently under the care of a physician? Yes or No

Are you allergic to any medication? Yes or No

List:_____

Are you currently taking ANY prescription medications? Yes or No

List:_____

Have you ever had a surgical operation? Yes or No

If yes, describe:

_____

_____

Have you ever had or currently have:

Y	**N**	Acquired Immune Deficiency	**Y**	**N**	Hemophilia
Y	**N**	Alleriges	**Y**	**N**	Hepatitis
Y	**N**	Anemia	**Y**	**N**	High Blood Pressure
Y	**N**	Angina	**Y**	**N**	High Cholesterol
Y	**N**	Anorexia/Bulimia	**Y**	**N**	HIV Positive
Y	**N**	Arthritis	**Y**	**N**	Joint Replacement (Knee/Hip)
Y	**N**	Asthma	**Y**	**N**	Kidney Disorder
Y	**N**	Blood Transfusion	**Y**	**N**	Liver Disease
Y	**N**	Chemically Dependent	**Y**	**N**	Pacemaker
Y	**N**	Chronic Ear Infections	**Y**	**N**	Pregnant Now?
Y	**N**	Chronic Sinus	**Y**	**N**	Radiation/Chemotherapy
Y	**N**	Diabetes	**Y**	**N**	Rheumatic Fever
Y	**N**	Emphysema	**Y**	**N**	Stroke
Y	**N**	Epilepsy/Seizures	**Y**	**N**	Thyroid Condition
Y	**N**	Excessive Bleeding	**Y**	**N**	Tuberculosis
Y	**N**	Heart Murmur	**Y**	**N**	Ulcers
Y	**N**	Heart Problems	**Y**	**N**	Venereal Disease
Y	**N**	Heart Surgery	**Y**	**N**	Do you use tobacco products?

Signature_____ Date_____

Reviewed by_____ Date_____