CONFIDENTIAL HEALTH HISTORY

Patient:_____ Date:_____

Please answer and print appropriate responses. An accurate and complete health history is critical in planning and performing proper care. All information is strictly confidential.

Physicians Name:_____ Phone Number:_____

Approximate date of last medical check up:_____

(A) GENERAL

1. Do you consider your health to be good? *Yes* *No*
2. Have you ever been hospitalized, had any serious illness or operation? *Yes* *No*
If Yes please explain:_____
_____
3. Has there been any recent change in your health? *Yes* *No*
4. Are you presently being treated by your physician or a specialist? *Yes* *No*
If Yes please explain:_____
_____
5. Are you presently taking any medications?
If Yes please list names and doses_____
_____
6. Are you allergic or have you reacted adversely to any medications? *Yes* *No*
If Yes please check below or provide examples_____

Penicillin	Aspirin	Valium	Sleeping Pills
Erythromycin	Codeine	Sulfonamide (Sulfa)	
Tetracycline	Percodan	Local Anesthetics	
Clindamycin	Demerol	Iodine	

7. Do you smoke? *Yes* *No*
If Yes how much per day: _____
8. When you walk stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? *Yes* *No*
9. Are you allergic to latex gloves? *Yes* *No*

(B) FOR WOMEN ONLY

1. Are you pregnant? *Yes* *No*
If Yes please provide your due date: _____
2. Are you taking birth control pills? *Yes* *No*

(C) SPECIFICS Do you have or have ever had any of the following:

1. Rheumatic fever? *Yes* *No*
2. Congenital heart disease? *Yes* *No*
3. Heart murmur and/or damaged heart valves? *Yes* *No*
4. Heart attack? *Yes* *No*
5. Congestive heart failure? *Yes* *No*
6. Pace maker, artificial valves or transplants? *Yes* *No*
7. Angina Pectoris (pain in the chest)? *Yes* *No*
8. Heart surgery? *Yes* *No*
9. Breathing problems e.g. asthma, emphysema, etc.? *Yes* *No*
10. Tuberculosis? *Yes* *No*
11. High or low blood pressure? *Yes* *No*

12. Stroke? *Yes* *No*
13. Blood disorders e.g. anemia, haemophilia, prolonged bleeding, bruising? *Yes* *No*
14. Blood transfusions? If so when? *Yes* *No*
15. Diabetes (sugar illness)? *Yes* *No*
16. Thyroid excess or insufficiency? *Yes* *No*
17. Hepatitis, jaundice or liver disease? *Yes* *No*

If yes please specify: _____

18. Kidney problem or dialysis? *Yes* *No*
19. Stomach or intestinal ulcers? *Yes* *No*
20. Digestive problems e.g. Crohn's disease? *Yes* *No*
21. Arthritis? If so what type and where in the body? *Yes* *No*
22. Artificial joints (knee or hip and when)? *Yes* *No*
23. Allergies and sensitivities? *Yes* *No*
24. Cancer or tumor? If so what type *Yes* *No*

If yes please specify: _____

25. Radiation or chemotherapy? *Yes* *No*
26. AIDS or positive for HIV? *Yes* *No*
27. Cold sores? *Yes* *No*
28. Venereal disease? (syphilis, gonorrhea etc.) *Yes* *No*
29. Fainting spells? *Yes* *No*
30. Epilepsy or convulsions? *Yes* *No*
31. Nervous disorders e.g. Parkinson's disease? *Yes* *No*
32. Psychiatric disorders? *Yes* *No*
33. Trauma to face or head? *Yes* *No*
34. Frequent headaches? If so where? *Yes* *No*
35. Vision problems? E.g. glaucoma? *Yes* *No*
36. Cosmetic surgery? *Yes* *No*
37. Sinus problems? *Yes* *No*
38. Hay fever? *Yes* *No*
39. Drug addiction? *Yes* *No*
40. Cortizone medication? *Yes* *No*
41. Sickle cell disease? *Yes* *No*
42. Scarlet fever? *Yes* *No*
43. Do you snore loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)? *Yes* *No*
44. Do you often feel tired, fatigued or sleepy during the daytime? *Yes* *No*
45. Has anyone observed you stop breathing/gasping during your sleep? *Yes* *No*

Are there any problems that have not been listed above? *Yes* *No*
If Yes please provide details_____
_____

Is there anything in this questionnaire that you did not understand? *Yes* *No*

PATIENT CERTIFICATION:
I, the undersigned that all of the above medical information is true to my knowledge and I have not omitted any pertinent information.

*Signature*_____ *Date*_____
*Signature of parent or guardian (if under 18)*_____

Summary:
_____
_____
_____
_____

Staff Signature:_____ Date:_____