HEALTH HISTORY

NAME:_____**DATE OF BIRTH**_____

GENERAL HEALTH ____EXCELLENT ____GOOD ___FAIR ___POOR

LIST OF MEDICATIONS AND PURPOSE:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ANY OTHER MEDICATIONS THAT YOU HAVE TAKEN IN THE LAST 3 MONTHS BUT ARE NOT CURRENTLY TAKING

_____

HAVE YOU EVER BEEN TREATED FOR:

ABNORMAL BLEEDING	Y OR N	ANEMIA	Y OR N
ALLERGIES	Y OR N	ALCOHOL/DRUG ABUSE	Y OR N
ANGINA	Y OR N	ARTHRITIS	Y OR N
ARTIFICIAL BONES	Y OR N	ARTIFICIAL HEART	Y OR N
ASTHMA	Y OR N	BLOOD TRANSFUSIONS	Y OR N
CANCER/CHEMO TX	Y OR N	COLITIS	Y OR N
CONGENITAL HEART	Y OR N	COSMETIC SURGERY	Y OR N
DIABETES	Y OR N	DIFFICULTY BREATHING	Y OR N
EPILEPSY	Y OR N	EPILEPSY	Y OR N
FAINTING SPELLS	Y OR N	FREQUENT HEADACHES	Y OR N
GLAUCOMA	Y OR N	HAY FEVER	Y OR N
HEART ATTACK	Y OR N	HEART SURGERY	Y OR N
HEMOPHILIA	Y OR N	HEPATITIS	Y OR N
HIGH BLOOD PRESSURE	Y OR N	HIV/AIDS	Y OR N
KIDNEY PROBLEMS	Y OR N	LIVER DISORDERS	Y OR N
LOW BLOOD PRESSURE	Y OR N	MITRAL VALVE	Y OR N
PACE MAKER	Y OR N	RADIATION	Y OR N
RHEUMATIC FEVER	Y OR N	SEIZURES	Y OR N
SHINGLES	Y OR N	SICKLE CELL DISEASE	Y OR N
SINUS PROBLEMS	Y OR N	STROKE	Y OR N
THYROID PROBLEMS	Y OR N	TUBERCULOSIS	Y OR N
ULCERS	Y OR N		