Health History

Please complete the following information for review by your provider

Name: _____ **Birth Date:** ____/____/____ **Age:** _____

Sex: ☐ M ☐ F **Family Doctor:** _____ **Occupation:** _____

Patient Medical History

☐ Heart Trouble	☐ High Blood Pressure	☐ Stroke	☐ Diabetes	☐ Arthritis
☐ Kidney Trouble	☐ Osteoporosis	☐ Bleeding Problems	☐ Lung Disease	☐ Asthma
☐ Blood Clots	☐ Anemia	☐ Stomach Ulcers	☐ Liver Trouble	☐ Cancer
☐ MRSA	☐ AIDS/HIV	☐ Hepatitis	☐ Other _____	

Previous Surgeries: ☐ None **Hospital/Date**

Previous Surgeries	Hospital/Date
1.	4.
2.	5.
3.	6.

Problems with anesthesia: ☐ Yes ☐ No

If Yes, Describe: _____

Allergies to Medications: ☐ None ☐ Yes, List →

Medication	Allergic Reaction

Medications you currently take (including over the counter medications, vitamins, herbs & prescribed drugs):

☐ **See separate medication list** ☐ **Not taking any medications as of** _____**(date)**

Date	Medication	Dosage/Frequency	Why are you taking this medication?

Patient Signature: _____ Date: _____