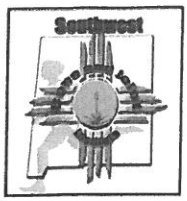


## Health History

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**

| | | | |
|---|---|---|---|
| 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? |
|---|---|---|---|
| | | | |
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Patient Signature: _____ Date: _____