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Health History Update

Patient Name:

Last First MI

Preferred Name

Do you presently have or have you had, please check all that apply:

- ☐ Under the care of a Physician during the past two years for a specific health concern
- ☐ Admitted in a hospital during the past two years
- ☐ Use Tobacco products
- ☐ Consume Alcoholic beverages
- ☐ Use recreational or street drugs
- ☐ Excessive bleeding requiring special treatment

Do you have any allergies or are you made ill by metals, jewelry, aspirin, drugs, foods, or medications? ◯ Yes ◯ No

If yes, please expain:

Do you presently have or have you had, please check all that apply:

☐ *Pre-Med	☐ Allergies Seasonal	☐ Allergy Amoxicillin	☐ Allergy Codeine
☐ Allergy Latex	☐ Allergy Other	☐ Allergy Penicillin	☐ Allergy Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Heart Vlv	☐ Artificial Joints
☐ Asthma	☐ Blood Disease	☐ Blood Transfusion	☐ Cancer Treatment
☐ Cardiac Pacemaker	☐ Chemotherapy	☐ Chest Pain	☐ Cold sores
☐ Currently Pregnant	☐ Diabetes	☐ Emphysema	☐ Epilepsy
☐ Fainting Spells	☐ Fibromyalgia	☐ Glaucoma	☐ Hay Fever
☐ Head Injuries	☐ Headaches	☐ Heart Disease	☐ Heart Murmur
☐ Heart Surgery	☐ Hemophilia	☐ Hep-B	☐ Hep-C
☐ Herpes	☐ High Blood Pressure	☐ HIV	☐ Irregular Heartbeat
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure
☐ Mental Disorders	☐ Mitral Valve Prolaps	☐ Nervous Disorders	☐ Persistent Cough
☐ Radiation Treatment	☐ Recent Weight Change	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Scarlet Fever	☐ Sinus Problems	☐ Sleep Apnea
☐ Stomach Problems	☐ Stroke	☐ Thyroid Disease	☐ Tuberculosis
☐ Tumors	☐ Ulcers	☐ XrayCobalt Treatment	

☐ Tire Easily ☐ Bruise Easily ☐ Special Diet ☐ Short of Breath ☐ None of the above

Do you have any disease, condition, or problem not listed? Please list:

Please list any prescription or non-prescription drugs you are currently taking:

☐ **To the best of my knowledge, all the preceding answers are true and correct.**

Signature _____ _____

Date

Provider review and comments:

Response Date: _____