Health History Form

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last / First / Middle) Home Phone: ( ) Cell Phone: ( )

Address: (Mailing address) City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Phone:

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems:

	Yes	No
Active Tuberculosis	☐	☐
Persistent cough greater than a 3 week duration	☐	☐
Cough that produces blood	☐	☐
Been exposed to anyone with tuberculosis	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No
Are you now under the care of a physician?	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No
Are you in good health?	☐	☐
Has there been any change in your general health within the past year?	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

SERIOUS ILLNESS OR PROBLEM

	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem?

____

CURRENT PRESCRIPTIONS/MEDICATIONS

	Yes	No
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

LIST MEDICATIONS: (Include Dosage & Frequency)

____

____

____

____

FAMILY HEALTH HISTORY: (please list any known family health issues)

____

____

____

____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Question	Yes	No
Do you wear contact lenses?	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐
Date: ______________ If yes, have you had any complications?_______________		
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐
Date Treatment began: ______________________________		
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED		
Do you drink alcoholic beverages?	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? ________________		
If yes, how much do you typically drink In a week? ________________		

WOMEN ONLY Are you:

Question	Yes	No
Pregnant?	☐	☐
Number of weeks: ____________		
Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Allergy	Yes	No
Local anesthetics____________________	☐	☐
Aspirin ____________________	☐	☐
Penicillin or other antibiotics ____________________	☐	☐
Barbiturates, sedatives, or sleeping pills ____________________	☐	☐
Sulfa drugs ____________________	☐	☐
Codeine or other narcotics ____________________	☐	☐
Metals____________________	☐	☐
Latex (rubber) ____________________	☐	☐
Iodine ____________________	☐	☐
Hay fever/seasonal ____________________	☐	☐
Animals____________________	☐	☐
Food ____________________	☐	☐
Other ____________________	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Condition	Yes	No
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)		
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Condition	Yes	No
Cardiovascular disease.	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
Other congenital heart defects	☐	☐
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
If yes, date:____________________		
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Systemic lupus erythematosus.	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus trouble	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐
Chest pain upon exertion	☐	☐
Chronic pain	☐	☐
Diabetes Type I or II	☐	☐
Eating disorder	☐	☐
Malnutrition	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Ulcers	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐
Glaucoma	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Neurological disorders	☐	☐
If yes, specify:________________		
Sleep disorder	☐	☐
Mental health disorders	☐	☐
Specify:________________		
Recurrent Infections	☐	☐
Type of infection:________________		
Kidney problems	☐	☐
Night sweats	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands in neck	☐	☐
Severe headaches/ migraines	☐	☐
Severe or rapid weight loss	☐	☐
Sexually transmitted disease	☐	☐
Excessive urination	☐	☐

Do you have any disease, condition, or problem not listed above?

Comments:____

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Signature of Patient/Legal Guardian:

Date: