

HEALTH HISTORY FOR ADULTS (19 AND OLDER)

Name _____ Home _____ Cell _____

Address _____ City: _____ State _____ Zip _____

Date of Birth _____ Employer _____ Phone _____

In case of emergency who should we contact? _____ Phone _____

Payment of Services: Insurance Cash Budget Plan Medicaid

Circle yes or no for any of the following that you have had or have at the present:

| | | | | | |
|--|--------|-------------------|--------|--------------------------|--------|
| High Blood Pressure | yes/no | Asthma | yes/no | Hepatitis Type _____ | yes/no |
| Angina | yes/no | Bleeding Disorder | yes/no | Stroke | yes/no |
| Heart Disease/Attack | yes/no | Heart Pacemaker | yes/no | Arthritis | yes/no |
| HIV Positive or AIDS | yes/no | Tuberculosis (TB) | yes/no | Anemia | yes/no |
| Sinus Problems | yes/no | Diabetes | yes/no | Tobacco use | yes/no |
| *Mitral Valve | yes/no | | | *Heart Murmur | yes/no |
| *Rheumatic fever | yes/no | | | *Artificial Heart valves | yes/no |
| *Artificial Hip, knee, or other joints | yes/no | | | *Shunts/ports | yes/no |
| *Breast Implants | yes/no | | | | |

*Antibiotic pre-medication may be required prior to your appointment.

Have you ever taken Phen-Fen/ Redux/ Pondimin? yes/no

Are you allergic to (i.e. itching, swelling, or rash) or made sick by Penicillin, Aspirin, Codeine, Sulfa, Local Anesthetics, Latex, Metals? (Circle the ones that apply.)

Or any other medications? _____

Women: Are you pregnant? YES or No

List ALL medications that you are currently taking: _____

Is there any other important health information we should know about you? _____

Whom should we thank for referring you to our office? _____

To the best of my knowledge, all of the information on this form is true and correct. If there is any change in my health, I will inform the doctor prior to any treatment.

Signature _____ Date _____

I have reviewed my medical history and the above is accurate: Date _____ Initials _____
Date _____ Initials _____ Date _____ Initials _____
Date _____ Initials _____ Date _____ Initials _____