

Health History Form



E-mail:	Today's Date:
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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:		Home Phone:		Cell Phone:	
Last	First	Middle	()	()	()
Address:			City:	State:	Zip:
<small>Mailing address</small>					
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?					
<small>Your Name</small>			<small>Relationship</small>		
Do you have any of the following diseases or problems:					
Active Tuberculosis.....					Yes No
Persistent cough greater than a 3 week duration.....					<input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....					<input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....					<input type="checkbox"/> <input type="checkbox"/>
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.

Are you now under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	SERIOUS ILLNESS OR PROBLEM
Physician Name: _____ Phone: <small>Include area code</small> ()	Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address/City/State/Zip: _____	If yes, what was the illness or problem? _____
Are you in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No	CURRENT PRESCRIPTIONS/MEDICATIONS
Has there been any change in your general health within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what condition is being treated? _____	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____
Date of last physical exam: _____	LIST MEDICATIONS: (Include Dosage & Frequency) _____ _____ _____ _____

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



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

Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use controlled substances (drugs)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No																								
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ If yes, have you had any complications? _____	Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED																								
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink alcoholic beverages?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____																								
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?..... <input type="checkbox"/> Yes <input type="checkbox"/> No Date Treatment began: _____	WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of weeks: _____ Taking birth control pills or hormonal replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No																								
Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.	Metals <input type="checkbox"/> Yes <input type="checkbox"/> No Latex (rubber) <input type="checkbox"/> Yes <input type="checkbox"/> No Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No Hay fever/seasonal <input type="checkbox"/> Yes <input type="checkbox"/> No Animals <input type="checkbox"/> Yes <input type="checkbox"/> No Food <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No																								
Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No																									
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.																									
Artificial (prosthetic) heart valve <input type="checkbox"/> Yes <input type="checkbox"/> No Previous infective endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No Damaged valves in transplanted heart <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital heart disease (CHD) Unrepaired, cyanotic CHD <input type="checkbox"/> Yes <input type="checkbox"/> No Repaired (completely) in last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No Repaired CHD with residual defects <input type="checkbox"/> Yes <input type="checkbox"/> No	Autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Systemic lupus erythematosus <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain upon exertion <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic pain <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes Type I or II <input type="checkbox"/> Yes <input type="checkbox"/> No Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Malnutrition <input type="checkbox"/> Yes <input type="checkbox"/> No Gastrointestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No G.E. Reflux/persistent heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No																								
Hepatitis, jaundice or liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting spells or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No Neurological disorders <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____ Sleep disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Mental health disorders <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____ Recurrent Infections <input type="checkbox"/> Yes <input type="checkbox"/> No Type of infection: _____ Kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No Night sweats <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No Persistent swollen glands in neck <input type="checkbox"/> Yes <input type="checkbox"/> No Severe headaches/ migraines <input type="checkbox"/> Yes <input type="checkbox"/> No Severe or rapid weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No Sexually transmitted disease <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive urination <input type="checkbox"/> Yes <input type="checkbox"/> No																									
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>																									
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Do you have any disease, condition, or problem not listed above? Comments: _____ _____																									

Signature of Patient/Legal Guardian:

Date: