

# Health History Form

Dr. \_\_\_\_\_

Name	Date
------	------

Address

D.O.B.	Age	Height	Weight	Home Phone	Work Phone
--------	-----	--------	--------	------------	------------

Reason for visit today?

**Past/Current Hx (Check all applicable)**

<input type="checkbox"/> Lung Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Keloids	<input type="checkbox"/> Abnormal or Excessive Bleeding
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> MRSA	<input type="checkbox"/> Taken Accutane with in Past Year
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> HIV	<input type="checkbox"/> Fever Blisters	<input type="checkbox"/> Neck Problems
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Use CPAP/BPAP				

**Other Major Illnesses:**

Medications: Name	Reason for Taking	Frequency/Dose

Do you take ANY Diet Pills, Natural Herbs or Health Food Supplements? If Yes, What: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies and Reactions to Medication? \_\_\_\_\_  
 \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you or anyone in your family had complications from anesthesia? If Yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has anyone in your family had breast cancer before the age of 50? If Yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Have you been on ANY steroids in the last year? If Yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Do you take aspirin on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have excessive bleeding or bruising? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any teeth that are: <input type="checkbox"/> Loose <input type="checkbox"/> Fragile
Do you use any Tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Capped <input type="checkbox"/> False

Signature	Date
-----------	------