Health History

Name _____ Date _____

Have you ever had or do you have now any of the following?
Please check those that apply.

- ☐ **Premedicate for Treatment**
- ☐ Anemia
- ☐ Aneurism
- ☐ Arthritis/Rheumatism
- ☐ Artificial Bones/Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemotherapy/Radiation
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting Spells/Dizziness
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV+/Aids
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Now Pregnant
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Severe/Frequent Headaches
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Tumors
- ☐ Ulcers/Colitis
- ☐ Venereal Disease
- ☐ Other _____

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☐ **No Health Concerns**

Please check allergies that apply:

- ☐ **No Allergies**
- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Augmentin
- ☐ Bactrim
- ☐ Barbituates (Sleeping Pills)
- ☐ Biaxin
- ☐ Ceclor
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other _____

_____

_____

List medications (prescription and over-the-counter), vitamins, minerals, and herbal remedies you are currently taking. _____

_____

_____

_____

Please list any other health conditions that we should be aware of: _____

_____

_____

I certify that I have read and understand the above information. To the best of my knowledge, I have answered all questions accurately. I understand that providing incorrect information may be dangerous to my health.

_____

Signature Date