

Health History

Date _____

Name _____
Last First Middle
Address _____
City _____ State _____ Zip Code _____
Place of Employment _____
Date of Birth _____ Sex: M F Height _____ Weight _____
Single Married
Home Phone _____
Business Phone _____
Cell Phone _____
Social Security No. _____
Name of Spouse _____ Name of Closest Relative not living with you _____ Phone of Relative _____
Your e-mail address _____
Who may we thank for referring you? _____
(Phone Book --- Name of Person --- Other)

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

- | | | | |
|-----|--|-----|----|
| 1. | Are you in good health?..... | Yes | No |
| 2. | Has there been any change in your general health within the past year? | Yes | No |
| 3. | My last physical examination was on _____ | | |
| 4. | Are you now under the care of a physician?..... | Yes | No |
| | If so, what is the condition being treated? _____ | | |
| 5. | The name(s) of my physician(s) is / are _____ | | |
| 6. | Have you had any serious illness, operation, or been hospitalized in the past five years? | Yes | No |
| | If so, what condition was treated? _____ | | |
| 7. | Are you taking any medicine(s) including non-prescription medicine? | Yes | No |
| | If so, what medicines are you taking? _____ | | |
| 8. | Have you taken any medications to treat osteoporosis or bone cancer? _____ | Yes | No |
| 9. | Please circle the letter of any of the conditions that may apply to you: | | |
| | a. Cardiovascular disease: heart trouble, artificial heart valves, heart attack, angina, high blood pressure, arteriosclerosis, stroke, or pacemaker | | |
| | b. Sinus trouble | | |
| | c. Fainting spells or seizures | | |
| | d. Persistent diarrhea or recent weight loss | | |
| | e. Diabetes | | |
| | f. Hepatitis, jaundice or liver disease | | |
| | g. AIDS or HIV infection | | |
| | h. Arthritis or painful swollen joints | | |
| | i. Stomach ulcer or hyperacidity | | |
| | j. Persistent swollen glands in neck | | |
| | k. Low blood pressure | | |
| | l. Sexually transmitted diseases | | |
| | m. Epilepsy or other neurological disease | | |
| | n. Problems with mental health | | |
| | o. Cancer | | |
| | p. Problems of the immune system | | |
| | q. Abnormal bleeding | | |
| 10. | Do you have any artificial joints? | Yes | No |
| 11. | Have you ever had any treatment for a tumor or growth? | Yes | No |
| 12. | Are you allergic to or have you had a reaction to: | | |
| | a. Local dental anesthetics..... | Yes | No |
| | b. Penicillin or other antibiotics..... | Yes | No |
| | c. Aspirin | Yes | No |
| | e. Latex | Yes | No |
| | f. Codeine, sedatives or other narcotics..... | Yes | No |
| | g. Metals or jewelry/any other allergies not listed | Yes | No |

