HEALTH HISTORY

Physician's name:_____Date of last visit_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	□ **Y** □ **N**	Fainting or dizziness	□ **Y** □ **N**	Scarlet Fever	□ **Y** □ **N**
Anemia	□ **Y** □ **N**	Glaucoma	□ **Y** □ **N**	Shortness of breath	□ **Y** □ **N**
Arthritis, Rheumatism	□ **Y** □ **N**	Headaches	□ **Y** □ **N**	Sinus Trouble	□ **Y** □ **N**
Artificial Heart Valves	□ **Y** □ **N**	Heart Murmur	□ **Y** □ **N**	Skin Rash	□ **Y** □ **N**
Artificial Joints	□ **Y** □ **N**	Heart Problems	□ **Y** □ **N**	Stroke	□ **Y** □ **N**
Asthma	□ **Y** □ **N**	Hepatitis Type_____	□ **Y** □ **N**	Swelling, Feet/Ankles	□ **Y** □ **N**
Back Problems	□ **Y** □ **N**	Herpes	□ **Y** □ **N**	Swollen Neck Glands	□ **Y** □ **N**
Bleeding abnormally, with extractions or surgery	□ **Y** □ **N**	High Blood Pressure	□ **Y** □ **N**	Thyroid Problems	□ **Y** □ **N**
		HIV Positive	□ **Y** □ **N**	Tonsillitis	□ **Y** □ **N**
		Jaundice	□ **Y** □ **N**	Tuberculosis	□ **Y** □ **N**
Blood Disease	□ **Y** □ **N**	Jaw Pain	□ **Y** □ **N**	Tumor or growth on head or neck	□ **Y** □ **N**
Cancer	□ **Y** □ **N**	Kidney Disease	□ **Y** □ **N**		
Chemical Dependency	□ **Y** □ **N**	Liver Disease	□ **Y** □ **N**	Ulcer	□ **Y** □ **N**
Chemotherapy	□ **Y** □ **N**	Low Blood Pressure	□ **Y** □ **N**	Venereal Disease	□ **Y** □ **N**
Circulatory Problems	□ **Y** □ **N**	Mitral Valve Prolapse	□ **Y** □ **N**	Weight Loss, unexplained	□ **Y** □ **N**
Cortisone Treatment	□ **Y** □ **N**	Pacemaker	□ **Y** □ **N**		
Cough, persistent or bloody	□ **Y** □ **N**	Psychiatric Care	□ **Y** □ **N**	**Women:**	
Diabetes	□ **Y** □ **N**	Radiation Treatment	□ **Y** □ **N**	Are you pregnant?	□ **Y** □ **N**
Emphysema	□ **Y** □ **N**	Respiratory Disease	□ **Y** □ **N**	Due date_____	
Epilepsy	□ **Y** □ **N**	Rheumatic Fever	□ **Y** □ **N**	Are you nursing?	□ **Y** □ **N**

Other medical information, not listed above?_____

MEDICATIONS / VITAMINS / SUPPLEMENTS	**ALLERGIES**
List medications you are currently taking: _____ _____ _____ _____ _____ _____ _____	☐ Aspirin ☐ Erythromycin ☐ Barbiturates (sleeping pills) ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Tetracycline ☐ Latex ☐ Other _____ _____

Pharmacy Name:_____Phone#:_____

Thank you for providing us this important information

Returning patients, has there been any change in your health since your last visit?
If so, what has changed?_____
New medications?_____
Patient signature_____Date_____
Doctor's signature_____Date_____

If so, what has changed?_____
New medications?_____
Patient signature_____Date_____
Doctor's signature_____Date_____