Confidential Health History:

Patient Name: First_____MI_____Last_____Date of Birth_____Today's Date_____

Do you have or have you had any of the following diseases or conditions? Circle Yes or No

Yes / No	Heart Surgery	Yes / No	Fainting or Dizzy Spells	Yes / No	Ulcers
Yes / No	Heart Attack / Heart Disease	Yes / No	Stroke	Yes / No	Arthritis, Rheumatism
Yes / No	Heart Murmur	Yes / No	Aneurisms	Yes / No	Gout
Yes / No	Heart Lesions	Yes / No	Sickle Cell Disease	Yes / No	Joint Pain or Stiffness
Yes / No	Artificial Heart Value / Pace Maker	Yes / No	Tuberculosis: TB	Yes / No	Hepatitis, A, B, C
Yes / No	Congenital Heart Problem	Yes / No	Asthma	Yes / No	Yellow Jaundice
Yes / No	Mitral Valve Prolapse	Yes / No	Emphysema, Lung Diseases	Yes / No	Venereal Disease
Yes / No	Shortness of Breath	Yes / No	Persistent Cough	Yes / No	Herpes
Yes / No	Bacterial Endocarditis	Yes / No	Coughing Up Blood	Yes / No	Unexplained Fever
Yes / No	Angina Pectoris Congenital	Yes / No	Breathing Problems	Yes / No	Unexplained Weight Loss
Yes / No	Chest Pain	Yes / No	Sinus Problems	Yes / No	Frequent Diarrhea
Yes / No	Circulatory Problems	Yes / No	Scarlet or Rheumatic Fever	Yes / No	Blood in Stool -Black Stool
Yes / No	Swollen Ankles, Hands, Feet	Yes / No	Seizures / Convulsions	Yes / No	Artificial Limbs, any prosthesis
Yes / No	High or Low Blood Pressure	Yes / No	Alzheimer's Disease	Yes / No	Diabetes / Amputation due to
Yes / No	Hardening of the Arteries	Yes / No	Epilepsy	Yes / No	Glaucoma
Yes / No	Cancer	Yes / No	Liver or Kidney Disease, Infections	Yes / No	Cold Sores, Fever Blisters
Yes / No	Tumors	Yes / No	Renal Dialysis	Yes / No	Skin Rashes or Welts
Yes / No	Chemotherapy, Radiation Therapy	Yes / No	Blood in Urine	Yes / No	Joint Replacements
Yes / No	Pulmonary Embolism	Yes / No	Parathyroid Disease	Yes / No	Organ Transplants
Yes / No	Neck or Jaw Aches	Yes / No	Thyroid Disease	Yes / No	Anemia
Yes / No	Bleeding Disorders, Clotting, Transfusions, Hemophilia	Yes / No	Skin Disease	Yes / No	Osteoporosis

This Information will not be released unless specifically authorized by the patient,

Yes / No	AIDS / HIV	Yes / No	Psychiatric Therapy, Hospital	Yes / No	Depression, Anxiety

Have you ever experienced any of the following?

Yes / No	Night sweats	Yes / No	Bruise easily	Yes / No	Difficulty urinating
Yes / No	Frequent Headaches	Yes / No	Frequent vomiting	Yes / No	Ringing in the ears
Yes / No	Frequent urination	Yes / No	Dry mouth	Yes / No	Blurred vision
Yes / No	Excessive thirst	Yes / No	Difficulty swallowing	Yes / No	Hay fever, Hives or Welts

Are you allergic to or have you had a reaction to any of the following?

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous Oxide
Yes / No	Metal	Yes / No	Erythromycin	Yes / No	Local Anesthetic (Novocain, Xylocaine)

Others not listed_____

Are you taking or have you taken any of the following in the last three months?

Yes / No	Recreational Drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-The-Counter Drugs	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight Loss Medicine, Fen-Phen, other	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Cortico - Steroids				

Women only

Yes / No Are you or could you be pregnant? If yes, what month?_____
Yes / No Are you nursing?_____
Yes / No Are you taking birth control pills?_____
Yes / No Do you anticipate becoming pregnant?_____