Name____ Date of Birth__________________________

Health History

CIRCLE

1. Are you having pain or discomfort at this time? . . . . Yes No
2. Have you been a patient in the hospital during the past two years? . . . . Yes No
3. Have you been under the care of a medical doctor during the past two years? . . . . Yes No
4. Are you taking any medication, drugs or pills? . . . . Yes No

   If yes, please list : ____

5. Are you allergic or have you reacted adversely to any of the following medications? . . . . Yes No

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erythromycin	Scopolamine	(Novacaine or Xylocaine)
Codeine	Tetracycline	Penicillin	Sleeping Pills
Demerol	Percodan	Other Antibiotics	

6. Are you aware of being allergic to any other medications or substance? . . . . Yes No

   If yes, please list: ______________________________________ Latex allergy? . . . . Yes No

7. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	HIV Positive
Heart Disease or Attack	Cough	A.I.D.S.
Angina Pectoris	Tuberculosis (TB)	Hepatitis A (infectious)
High Blood Pressure	Asthma	Hepatitis B (serum)
Heart Murmur	Hay Fever	Hepatitis C
Rheumatic Fever	Sinus Trouble	Liver Disease
Congenital Heart Lesions	Allergies or Hives	Yellow Jaundice
Scarlet Fever	Diabetes	Drug Addiction
Artificial Heart Valve	Thyroid Disease	Venereal Disease
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Fever Blisters
Artificial Joints (Hip,Knee)	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medication	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
Mitral Valve Prolapse	Bruise Easily	Hemophilia

8. Have you ever been tested for HIV?______ results: POS___ NEG___
9. When you walk up the stairs or take a walk, do you ever have to stop because of pain in you chest or shortness of breath, or because you are very tired? . . . . Yes No
10. Do you use tobacco products? _______ if so, what and how much ____________________________________
11. Do your ankles swell during the day? . . . . Yes No
12. Do you use more than two pillows to sleep? . . . . Yes No
13. Have you lost or gained more than 10 pounds in the past year? . . . . Yes No
14. Do you ever wake up from sleep short of breath? . . . . Yes No
15. Are you on a special diet? . . . . Yes No
16. Has you medical doctor ever said you had cancer or a tumor? . . . . Yes No
17. Do you have any disease, condition, or problem not listed? . . . . Yes No

    If yes please describe:____

For Women Only

Are you pregnant? Yes___ No___ If yes , what month?______ Are you taking birth control pills? Yes No

ABOVE INFORMATION IS TRUE

Patient/Guardian Signature ____ Date ___/___/___