

HEALTH HISTORY

<u>Patient Name:</u> []	<u>PID:</u> []	<u>Date:</u> []
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MEDICAL ALERT	<u>Condition:</u> []	<u>Premedication:</u> []
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		YES	NO
1.	Have you visited a physician for a medical condition in the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, please explain. [] Physician : [] Phone : []		
2.	When was your last visit to a Physician? [] Last complete physical examination? []		
3.	Are you presently taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Or have you recently taken any?	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, please list: [] [] [] [] [] []		
4.	Have you been hospitalized in the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever reacted adversely to any of the following?		
	Antibiotics - Penicillin.	<input type="checkbox"/>	<input type="checkbox"/>
	Sulfonamide.	<input type="checkbox"/>	<input type="checkbox"/>
	other antibiotics.	<input type="checkbox"/>	<input type="checkbox"/>
	Aspirin.	<input type="checkbox"/>	<input type="checkbox"/>
	Barbiturates (sleeping pills).	<input type="checkbox"/>	<input type="checkbox"/>
	Codeine.	<input type="checkbox"/>	<input type="checkbox"/>
	Darvon.	<input type="checkbox"/>	<input type="checkbox"/>
	Local Anaesthetic (freezing).	<input type="checkbox"/>	<input type="checkbox"/>
	Nitrous oxide.	<input type="checkbox"/>	<input type="checkbox"/>
	Any other medication, please list. []	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever been advised against taking any specific type of medication? []	<input type="checkbox"/>	<input type="checkbox"/>

7.	Do you have any of the following?								
	Asthma.	Y <input type="checkbox"/>	N <input type="checkbox"/>	Hay Fever.	Y <input type="checkbox"/>	N <input type="checkbox"/>			
	Food Allergies.	Y <input type="checkbox"/>	N <input type="checkbox"/>	Metal or Latex Allergies.	Y <input type="checkbox"/>	N <input type="checkbox"/>			
	Skin Rashes.	Y <input type="checkbox"/>	N <input type="checkbox"/>	Hives.	Y <input type="checkbox"/>	N <input type="checkbox"/>			
	Any other allergic condition.	Y <input type="checkbox"/>	N <input type="checkbox"/>						
8.	Has any family member had diabetes?						<input type="checkbox"/>	<input type="checkbox"/>	
9.	Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?						<input type="checkbox"/>	<input type="checkbox"/>	
10.	Do your ankles, feet or hands swell?						<input type="checkbox"/>	<input type="checkbox"/>	
11.	Has your weight, appetite or energy level changed dramatically recently?						<input type="checkbox"/>	<input type="checkbox"/>	
12.	Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?						<input type="checkbox"/>	<input type="checkbox"/>	
13.	Do you follow a special diet?						<input type="checkbox"/>	<input type="checkbox"/>	
14.	Have you recently tested HIV positive?						<input type="checkbox"/>	<input type="checkbox"/>	
15.	Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections?						<input type="checkbox"/>	<input type="checkbox"/>	
16.	Have you ever had any injury or surgery to your face or jaws?						<input type="checkbox"/>	<input type="checkbox"/>	
17.	Do you wear eyeglasses or contact lenses?						<input type="checkbox"/>	<input type="checkbox"/>	
18.	Do you have any hearing difficulties?						<input type="checkbox"/>	<input type="checkbox"/>	
19.	Do you smoke or use any other forms of tobacco?						<input type="checkbox"/>	<input type="checkbox"/>	
	Are you wearing the transdermal nicotine patch?						<input type="checkbox"/>	<input type="checkbox"/>	
20.	Are you alcohol and/or drug dependent?						<input type="checkbox"/>	<input type="checkbox"/>	
	Have you received treatment?						<input type="checkbox"/>	<input type="checkbox"/>	
21.	INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:								
		Yes	No		Yes	No	Yes	No	
	A.I.D.S.	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>
	Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints (hip, knee)	<input type="checkbox"/>	<input type="checkbox"/>
	Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
	Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone/steroid	<input type="checkbox"/>	<input type="checkbox"/>
	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>
	Fainting or dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Glandular disorders	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>

Head/neck injuries	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or attack	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>			
Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Heart rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>			
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	High/Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hodgkins disease	<input type="checkbox"/>	<input type="checkbox"/>			
Hyper (Hypo) Glycemia	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>			
Malignant hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	Mental/nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>			
Organ transplant/medical transplant	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment/chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic/Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>			
Stomach/intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>			
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="text"/>										
22.	Has the CHILD PATIENT <u>recently</u> had any of the following (indicate approximate date):										
			Yes	No		Yes	No				
Measles	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Chicken Pox	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strep throat	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Tonsillitis	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>								
23.	WOMEN ONLY:										
	Are you pregnant or suspect you might be?									<input type="checkbox"/>	<input type="checkbox"/>
	If yes, what is the expected birth date? <input type="text"/>										
	Are you taking any birth control pills?									<input type="checkbox"/>	<input type="checkbox"/>
24.	Do you currently have, or have you had in the past, any disease, condition, or problem not listed above?									<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text"/>										
25.	Is there anything else about your health we should be made aware of?									<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text"/>										
26.	Do you wish to speak to the Doctor privately about any problem or medical condition?									<input type="checkbox"/>	<input type="checkbox"/>