HEALTH HISTORY FORM

NAME: _____ **DATE:** _____

ADDRESS: _____

HOME PHONE: _____ **WORK:** _____

DOB: _____ **AGE:** _____ **HEIGHT:** _____ **WEIGHT:** _____

What is the reason for your visit today? _____

_____

PAST/CURRENT HX: (Check if applicable)

Mitral Valve Prolapse	☐	**High Blood Pressure**	☐	**Neck Problems**	☐
Lung Disease	☐	**Heart Disease**	☐	**Sleep Apnea**	☐
Liver Disease	☐	**Chest Pains**	☐	Use CPAP/BPAP	☐
Kidney Disease	☐	**Diabetes**	☐	**Dry Eyes**	☐
Seizures	☐	**Asthma**	☐	**Fever Blisters**	☐
Rheumatic Fever	☐	**Hepatitis**	☐	**Taken Accutane**	
Chronic Cough	☐	**HIV**	☐	**within past year**	☐

Other Major Illnesses: _____

Medications:	**Name:**	**Reason for taking:**	**Frequency/Dose:**
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Do you take ANY diet pills? If so, what: _____

Do you take ANY natural herbs or supplements? If so, what: _____

Allergies and reactions to medications: _____

_____

Previous Surgeries: _____

_____

Have you or a family member had complications from anesthesia? If YES, please explain:

_____

Do you have any teeth that are: Loose_____ **Fragile**_____ **Capped** _____ **False** _____

Have you been on ANY steroids in the last year? If YES, please explain:

_____

Do you take aspirin on a regular basis?	**Yes** _____	**No** _____
Do you have excessive bleeding or bruising?	**Yes** _____	**No** _____
Do you use any tobacco products?	**Yes** _____	**No** _____
Are you pregnant?	**Yes** _____	**No** _____

Signature: _____ **Date:** _____