CONFIDENTIAL HEALTH HISTORY

Please Print

Patient's Name ____

Circle any of the following which you have had, or now have:

Heart Trouble	Tuberculosis	Glaucoma
Heart Murmur	Hepatitis	Venereal Disease
Rheumatic Fever	Stroke	Kidney Trouble
High Blood Pressure	Liver Trouble	Lung / Breathing Trouble
Radiation Therapy	Blood Disorders	Psychiatric Treatment
Fainting Spells	Asthma	Excessive Bleeding
Epilepsy / Seizures	Ulcers	Prosthetic joints
HIV / Antibodies	Diabetes	Pacemaker

Any other conditions not listed ____

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Are you allergic to, or suffer any ill-effects from:

____Penicillin ____Latex

____Codeine ____Any other drug ______________________________

____Aspirin

List all medications you are presently taking:

Medication	Dosage	Reason

Is there any other information about your health we should know?

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Physician's Name ____

Are you pregnant?_______If Yes, what month?__________

Are you taking hormones or birth control medication?___________

Are you breast feeding?__________

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I affirm that the above information is accurate to the best of my knowledge.

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Signature of Patient or Legal Guardian Date