

Confidential Patient Health History

Date _____

Patient Name: _____

Have you ever had any of the following: (Circle Y or N)

Heart Disease	Y N	Hepatitis A, B, or C	Y N	Mumps	Y N
Diabetes	Y N	Lung Disease	Y N	Chickenpox	Y N
Prolapsed Mitral Valve	Y N	Rheumatic Fever	Y N	Whooping Cough	Y N
Glaucoma	Y N	Arthritis	Y N	Scarlet Fever	Y N
Tuberculosis	Y N	HIV / AIDS	Y N	Diphtheria	Y N
Bronchitis	Y N	Kidney Disease	Y N	Smallpox	Y N
Liver Disease	Y N	Thyroid Disease	Y N	Venereal Disease	Y N
Measles	Y N	Ulcers	Y N	Anemia	Y N
Stroke	Y N	Mental/Psychiatric Disorder	Y N	Bladder Infection	Y N
Heart Attack	Y N	Heart Murmur	Y N	Migraine Headaches	Y N
Pacemaker	Y N	Colitis	Y N	Polio	Y N
Metal Implants	Y N	Epilepsy	Y N	Hernia	Y N
Swollen Ankles	Y N	Artificial Prosthesis	Y N	Blood or Plasma Transfusions	Y N
Sinusitis	Y N	Hearing Loss	Y N	Back Trouble	Y N
Asthma	Y N	Pregnant	Y N	High Blood Pressure	Y N
Hemorrhoids	Y N	Cancer	Y N	Low Blood Pressure	Y N
Hives or Eczema	Y N	Mono	Y N	Date of Last Chest Xray	

Previous Hospitalizations/Surgeries/Serious Illness (Please explain) _____

Please list any and all **ALLERGIES**: _____

Please list any medications that you take (prescription and over the counter) : _____

Patient social history:

Use of alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Rarely Moderate Previously, but quit: (date) _____ Current packs/day: _____

Use of Drugs: Never Type/Frequency: _____

Excessive exposure to (at home or at work): Fumes Dust Solvents Airborne Particles Noise

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Siblings			
Spouse			
Children			
Children			