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Health History Sheet

Name (Please Print):_____

Presenting problem or reason for visit: _____

Check if applicable:

Anemia / Bleeding Problems _____
Arthritis / Osteoporosis _____
Cancer_____
Diabetes _____
Breathing / Lung Problems _____
Epilepsy / Seizures _____
Fainting Spells _____
Glaucoma / Cataracts _____
Hepatitis _____
Heart Attack _____
Irregular Heart Rate _____
Kidney Disease _____
Rheumatic Fever / Murmur _____
Stroke _____
Thyroid Disease _____
Tuberculosis _____
Ulcers _____
HIV / AIDS _____
Heart Disease / Hypertension _____

Have you ever had a blood transfusion? (*Circle one*) **YES NO**

Do You Drink Any Alcoholic Beverages? (*Circle one*) **YES NO**

Do You Smoke? (*Circle one*) **YES NO** If yes, How long? _____ How Often? _____

Have You Ever Taken Accutane? (*Circle one*) **YES NO**

Have You Ever Taken Viagra? (*Circle one*) **YES NO**

List Any Present Medications: _____
_____

List Over The Counter Medications / Herbal Supplements / Multi Vitamins / ASA or Aspirin Related Products:
_____

Any Allergies To Medications: _____

List Any Previous Surgeries: _____

Last Pregnancy _____ Last Mammogram _____

SIGNATURE: _____ Date: _____