Patient Health History Today's Date:__________________

Patient:____________________________________ Date of Birth:____________ Age:______

Are you allergic to any medications? ____yes ____no If yes, list below:
1.)__________________________ 2.)______________________________

Have you ever had dental anesthesia (Novocain)? ____yes ____no
Any bad reactions? ___yes ____no Reaction: ____________________________

List all medications you are currently taking (including prescriptions, over-the-counter, vitamins, and herbals) : Use back of page if necessary.

1.)_______________________________ 2.)_________________________________

3.)_______________________________ 4.)_________________________________

5.)_______________________________ 6.)_________________________________

7.)_______________________________ 8.)_________________________________

Do you now have, or have you ever had diseases or conditions of: (Please check yes or no)

Lungs:	**Yes**	**No**
Bronchitis	___	___
Emphysema	___	___
Asthma	___	___
Chronic Cough	___	___
Morning Cough	___	___
Shortness of Breath	___	___
Wheezing	___	___

Cardiovascular:	**Yes**	**No**
High Blood Pressure	___	___
Chest Pain	___	___
Heart attack	___	___
Heart Murmur	___	___
Irregular Heartbeat	___	___
Phebitis	___	___
Inflammation of vein	___	___
Blood clots	___	___
Pacemaker	___	___

Other systemic:	**Yes**	**No**
Diabetes	___	___
Excessive thirst/hunger	___	___
Fainting	___	___
Thyroid	___	___
Kidney	___	___
Dialysis	___	___
Bladder	___	___
Frequency/burning	___	___
Gastrointestinal	___	___
Stomach absorptive disorder	___	___
Nausea, vomiting, diarrhea when taking antibiotics	___	___
Yeast infections when taking antibiotics	___	___
Arthritis/Joint deformity	___	___
Arthralgia	___	___
Limited motion	___	___
Artificial joint	___	___
Convulsions, Epilepsy, Seizures	___	___

List any other diseases or conditions:

____

____

List surgical procedures in the last 6 months:

____

____

 Patient Name: ___________________________

Skin:	**Yes**	**No**
Have you ever had skin cancer?	___	___
Has anyone in your family had skin cancer?	___	___
Do you bleed easily?	___	___
Do you have problems with healing?	___	___
Do you develop keloids (scars) after surgery?	___	___
Do you have a history of any specific skin diseases?	___	___

If yes please list:____

Do you develop skin rashes in reaction to: ___Medication, ___Food, ___ Environment, ___ Bandages, ___ Topical Neosporin, ____ Other:_____________________________________

Social History:	**Yes**	**No**	
Do you drink alcohol?	___	___	If yes, ___ drinks per day week month year
Do you smoke?	___	___	If yes, how much? ____What age did you start? _______
Do you use IV drugs?	___	___	If yes, what? ____________________________________

Have you had or have you been exposed to HIV (AIDS) or Hepatitis? ___ yes ___no

What is your occupation? ____

What are your hobbies? ____

Signed by Patient:__________________________________ Date:_____________

Reviewed by: _____________________________________ Date: _____________