HEALTH HISTORY

Name:_____ Date of Birth:_____
Referred by:_____
Who is your personal physician?_____
His/Her address & phone#:_____
Pharmacy Name & Phone #:_____
Do you have or have you ever been treated for any of the following?

Cancer	Yes____No____	High Cholesterol	Yes____No____
Duodenal or Peptic ulcers	Yes____No____	Liver Disease	Yes____No____
Tuberculosis/lung disease	Yes____No____	Bronchitis	Yes____No____
Emphysema	Yes____No____	Blood Transfusion	Yes____No____
Asthma	Yes____No____	Pulmonary Disease	Yes____No____
Heart Disease	Yes____No____	Hay Fever	Yes____No____
Diabetes Mellitus	Yes____No____	Renal Disorders	Yes____No____
Thyroid Disorders	Yes____No____	Hepatitis	Yes____No____
Bladder Disorders	Yes____No____	Arthritis	Yes____No____
Stomach or Bowl Disease	Yes____No____	Fainting	Yes____No____
Glaucoma	Yes____No____	Headaches	Yes____No____
Seizures	Yes____No____	Have you been exposed	
Convulsive Disorder	Yes____No____	To HIV (AIDS)?	Yes____No____
High Blood Pressure	Yes____No____		

SKIN:
When exposed to the sun, do you: Tan Only__Tan & Burn__Burn Only___
Have you ever had skin cancer? Yes____No____Please list:_____
Has anyone in your family had skin cancer? Yes____No____Who & What Type____
Do you have a history of any skin diseases? Yes____No____Please List_____
Have you had any recent operations? Yes_____No___Explain:_____
Do you bleed easily or excessively? Yes_____No___
Have you ever had a bad reaction on anesthesia? Yes____No____
Are you allergic to any medications? Please list:

_____
List any medications you are taking (including vitamins, aspirin, laxatives, birth control):

_____

Do you smoke?	Yes____No____	#____packs per day x___years
Do you drink alcohol?	Yes____No____	#____drinks per day
Are you pregnant?	Yes____No____	
Do you have artificial joints?		Height_____
Or limbs	Yes____No____	Weight_____

Signature:_____Date:_____