Health History

Have you ever had any of the following:

			If yes, when was the condition first apparent?
YES	NO	Head Injury with loss of consciousness	______
YES	NO	Seizures	______
YES	NO	Stroke	______
YES	NO	Heart Attack	______
YES	NO	Rheumatic Fever	______
YES	NO	Rheumatic Heart Disease	______
YES	NO	Heart Murmur	______
YES	NO	Congestive Heart Failure	______
YES	NO	Angina	______
YES	NO	Cardivascular Disease	______
YES	NO	High Blood Pressure	______
YES	NO	Tumor or Cancer	______
YES	NO	High Cholesterol	______
YES	NO	Diabetes	______
YES	NO	Thyroid Condition	______
YES	NO	Incontinence	______
YES	NO	Asthma	______
YES	NO	Emphysema	______
YES	NO	COPD	______
YES	NO	Liver Disease	______
YES	NO	Kidney Disease	______
YES	NO	Sleep Apnea	______
YES	NO	Alcohol Abuse	______
YES	NO	Drug Abuse	______
YES	NO	Osteoarthritis	______
YES	NO	Rheumatiod Arthritis	______
YES	NO	Psoriasis	______
YES	NO	Stomach Ulcers	______
YES	NO	Tuberculosis	______
YES	NO	Depression	______
YES	NO	Anxiety	______
YES	NO	Anemia	______
YES	NO	Venereal Disease	______

YES NO Do you see your physican on a regular basis?
If so, when was your last physical? ______

YES NO Are you currently being treated for any chronic illness?
If so, please list

______

______

Health History Continued

Please list all medications that you have taken in the last six months, dosages and frequency.

Medication	Dosages	Frequency

YES NO Are you allergic to any medications that you know of.

If yes, please list.

____

____

____

____

YES NO Are you allergic to Latex?

WOMEN

YES NO Are you or do you think you maybe pregnant?
If so, what is your due date? ________________

______________________________ ________________
Signature Date