

PATIENT HEALTH HISTORY

PATIENT'S NAME : LAST	FIRST	INITIAL	TODAY'S DATE
PHYSICIAN'S NAME		PHYSICIAN'S LOCATION (CITY)	DATE LAST TO PHYSICIAN

● DO YOU CURRENTLY HAVE OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING CONDITIONS?
 ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE.

NO.	CONDITION	YES	NO	DON'T KNOW	NO.	CONDITION	YES	NO	DON'T KNOW
1.	Allergies or drug reactions	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	19.	Hormone disorder	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
2.	Arthritis (rheumatoid, other)	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	20.	Drug abuse (including alcohol)	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
3.	Asthma	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	21.	Kidney disorders	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
4.	AIDS or positive HIV test	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	22.	Liver disorders	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
5.	Back pain	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	23.	Lung disorders	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
6.	Bleeding - prolonged	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	24.	Nose / throat disorder	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
7.	Blood disorder	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	25.	Replacement heart valve	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
8.	Blood pressure - high or low	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	26.	Replacement joint	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
9.	Cancer / tumor	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	27.	Rheumatic fever	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
10.	Diabetes	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	28.	Stomach disorders	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
11.	Emotional problems	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	29.	Stroke	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
12.	Epilepsy	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	30.	Tonsils / adenoids removed	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
13.	Eye problems (glaucoma, other)	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	31.	Tuberculosis	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
14.	Fainting or dizzy spells	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	32.	Thyroid disorder	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
15.	Hepatitis / hepatitis carrier	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	33.	Venereal disease	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
16.	Heart murmur	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	34.	Are you taking any medications?	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
17.	Heart disorders - other	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	35.	Are you taking any herbs?	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>
18.	Smoking	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	36.	Other (describe below)	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>

IF PATIENT IS A MINOR FEMALE, HAS SHE HAD HER FIRST MENSTRUAL CYCLE ?
 (This information will help in growth forecasting.) YES NO

NO.	FOR ANY "YES" ANSWERS TO HEALTH QUESTIONS ABOVE, PLEASE LIST THE QUESTION NUMBER AND DESCRIBE THE CONDITION