CONFIDENTIAL HEALTH HISTORY

Patient Name: _____

Medical Doctor's Name: _____

Phone No: _____

Do you have or have you ever had ?
(please check):

_____ Heart disease or heart attack
_____ Angina
_____ Prosthetic (artificial) heart valve or joint
_____ Rheumatic fever
_____ High or low blood pressure
_____ Stroke
_____ Blood disorders
_____ Anemia
_____ Prolonged bleeding
_____ Hepatitis
_____ Blood transfusion
_____ Human immunosuppressant virus/Antibodies
_____ Ulcers
_____ Kidney disease
_____ Severe infections
_____ Diabetes
_____ Cancer or tumor
_____ Psychiatric treatment
_____ Epilepsy
_____ Radiation (X-ray) therapy
_____ Asthma or hay fever
_____ Surgery
_____ Tuberculosis
_____ Liver disease

Are you presently under a physician's care? Yes _____ No _____

Reason: _____

Do you require (antibiotic or sedative) premedication? _____ Why? _____

_____

List all medications you are presently taking:

Medication	Action

Are you allergic or suffer ill-effects from:

_____ Penicillin Others: _____

_____ Aspirin _____

_____ Codeine _____

Women only: Are you pregnant? _____ What month? _____

Are you taking any hormonal/birth control medication? _____

I affirm that the above information is accurate to my best knowledge.

Signature: _____ Date: _____
(Patient or Guardian)

Update: _____ Date: _____