HEALTH HISTORY

Patient's name:_____Date:_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	❑ Y	❑ N	Heart Murmur	❑ Y	❑ N	Swelling, Feet/Ankles	❑ Y	❑ N
Anemia	❑ Y	❑ N	Heart Problems	❑ Y	❑ N	Swollen Neck Glands	❑ Y	❑ N
Arthritis, Rheumatism	❑ Y	❑ N	Hepatitis Type_____	❑ Y	❑ N	Thyroid Problems	❑ Y	❑ N
Artificial Heart Valves	❑ Y	❑ N	Herpes	❑ Y	❑ N	Tonsillitis	❑ Y	❑ N
Artificial Joints	❑ Y	❑ N	High Blood Pressure	❑ Y	❑ N	Tuberculosis	❑ Y	❑ N
Asthma	❑ Y	❑ N	HIV Positive	❑ Y	❑ N	Tumor or growth on		
Back Problems	❑ Y	❑ N	Jaundice	❑ Y	❑ N	head or neck	❑ Y	❑ N
Bleeding abnormally, with			Jaw Pain	❑ Y	❑ N	Ulcer	❑ Y	❑ N
extractions or surgery	❑ Y	❑ N	Kidney Disease	❑ Y	❑ N	Venereal Disease	❑ Y	❑ N
Blood Disease	❑ Y	❑ N	Liver Disease	❑ Y	❑ N	Weight Loss,		
Cancer	❑ Y	❑ N	Low Blood Pressure	❑ Y	❑ N	unexplained	❑ Y	❑ N
Chemical Dependency	❑ Y	❑ N	Mitral Valve Prolapse	❑ Y	❑ N			
Chemotherapy	❑ Y	❑ N	Pacemaker	❑ Y	❑ N			
Circulatory Problems	❑ Y	❑ N	Psychiatric Care	❑ Y	❑ N	Women:		
Cortisone Treatment	❑ Y	❑ N	Radiation Treatment	❑ Y	❑ N	Are you pregnant?	❑ Y	❑ N
Cough, persistent or bloody	❑ Y	❑ N	Respiratory Disease	❑ Y	❑ N	Due date_____		
Diabetes	❑ Y	❑ N	Rheumatic Fever	❑ Y	❑ N	Are you nursing?	❑ Y	❑ N
Emphysema	❑ Y	❑ N	Scarlet Fever	❑ Y	❑ N			
Epilepsy	❑ Y	❑ N	Shortness of breath	❑ Y	❑ N			
Fainting or dizziness	❑ Y	❑ N	Sinus Trouble	❑ Y	❑ N	Other medical information, not listed above?		
Glaucoma	❑ Y	❑ N	Skin Rash	❑ Y	❑ N	_____		
Headaches	❑ Y	❑ N	Stroke	❑ Y	❑ N	_____		

MEDICATIONS

List medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES

❑ Aspirin
❑ Barbiturates(sleeping pills)
❑ Codeine
❑ Tetracycline
❑ Erythromycin
❑ Penicillin
❑ Sulfa
❑ Latex
❑ Other _____

_____
_____
_____
_____

Physicians Name:_____Phone#:_____

Thank you for providing us this important information

Returning patients, has there been any change in your health since your last visit?
If so, what has changed?_____
New medications?_____
Patient signature_____Date_____
Doctor's signature_____Date_____
If so, what has changed?_____
New medications?_____
Patient signature_____Date_____
Doctor's signature_____Date_____

HEALTH HISTORY (Continued)

Tobacco Use

1. Do you CURRENTLY use tobacco? *(If no, go to question 4)

a. If you smoke cigarettes now, how many per day? _____
b. If you smoke cigars now, how many per day? _____
c. If you smoke a pipe now, how many pipefuls per day? _____
d. If you use 'smokeless' tobacco now, how many times per day? _____

2. How ready (or motivated) are you to quit tobacco use at present? Please circle the appropriate number.

(0=Not ready, 5=somewhat ready, 10=very ready)

0 1 2 3 4 5 6 7 8 9 10

3. What are the major obstacles to your quitting tobacco?

4. If you DO NOT CURRENTLY smoke or use tobacco products, have you in the past?

5. Do you live with people who smoke?

6. If you currently use tobacco or if you used tobacco in the past, what is the total number of years you have used tobacco? _____ (years)

7. If you currently use tobacco or if you used tobacco in the past, check the one statement that best reflects your current use of tobacco products:

[ ] I am currently using tobacco, and I do not intend to stop using tobacco in the next six months;
[ ] I am currently using tobacco, but I intend to stop using tobacco in the next six months;
[ ] I am currently using tobacco, but I intend to stop using tobacco in the next month;
[ ] I have not used tobacco at all for less than the past six months;
[ ] I have not used tobacco at all for the past 6 months or more.