HEALTH HISTORY

YES	NO	DISEASES	YES	NO	DISEASES
		Irregular Heart Beat			Prostate Problems
		Congestive Heart Failure			Liver Disease, Type:
		Heart Attack			Hepatitis? When?
		Stroke			Gallstones
		Heart Murmur			Arthritis? Osteo or RA
		Pace Maker (chest pain?)			Fibromyalgia
		High Blood Pressure			Gout
		High Cholesterol			Thyroid Problems
		Diabetes / High Blood Sugar			Cancer? Type:
		Asthma			Epilepsy / Seizures
		Emphysema / Chronic Bronchitis			Rheumatic Fever
		Sleep Apnea			Muscle Weakness
		Do you wear oxygen?			Anemia / Low Blood
		Tuberculosis			Skin Diseases? Type:
		Blood Clot in Leg			Glaucoma
		Blood Clot in Lung			Hearing Aid
		Bleeding Problems, Type:			Claustrophobia
		Blood Transfusion			Depression
		Ulcers in Bowel / Stomach			Anxiety
		Bleeding from Bowels			Other:
		Kidney Disease, Type:			
		Kidney Stones			

When was you most recent physical?_____ Labs?_____ EKG?_____

With which provider?_____

Please list all treating physician names and phone numbers:

_____

_____

_____

Patient Signature: _____ **Date:** _____