

# PATIENT HEALTH RECORD

Date \_\_\_\_\_

Name \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
(last) (first) (initial)

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Single \_\_\_\_\_

Closest Relative \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

**MEDICAL HEALTH**

Name and Address of Physician \_\_\_\_\_

Have you been under a physician's care during the past 2 years? \_\_\_\_\_ For? \_\_\_\_\_

Have you been treated in a hospital in the past 2 years? \_\_\_\_\_ For? \_\_\_\_\_

Have you ever had major surgery? \_\_\_\_\_

If female: Are you taking hormone's or birth control? \_\_\_\_\_ Are you pregnant or nursing? \_\_\_\_\_

Have you ever had a blood test for hepatitis? \_\_\_\_\_ Were you vaccinated? \_\_\_\_\_

Have you had cankers or cold sores on your lips, tongue, gums, or body? \_\_\_\_\_

Are you now taking or have you taken any prescription drugs during the past year? \_\_\_\_\_ List \_\_\_\_\_

\_\_\_\_\_ Are you allergic to:

Penicillin  Codeine  Local Anesthetics  Other \_\_\_\_\_

Are you taking or have you ever taken any of the following medications (Circle): ACTONEL, FOSOMAX, BONIVA, SKELID, DI-DRONEL, AREDIA, ZOMETA, BONEFOS

Have you had or do you now have

	yes	no		yes	no
Abnormal blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints.....	<input type="checkbox"/>	<input type="checkbox"/>	Polio.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged cough.....	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	Phychiatric treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Drug dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease.....	<input type="checkbox"/>	<input type="checkbox"/>

Have you any disease, condition, or problem not previously listed? \_\_\_\_\_