Health History Form

Dr. _____

Name					Date
Address					
D.O.B.	Age	Height	Weight	Home Phone	Work Phone
Reason for visit today?					

Past/Current Hx (Check all applicable)

☐ Lung Disease	☐ High Blood Pressure	☐ Asthma	☐ Keloids	☐ Abnormal or Excessive Bleeding
☐ Liver Disease	☐ Mitral Valve Prolapse	☐ Hepatitis	☐ MRSA	☐ Taken Accutane with in Past Year
☐ Kidney Disease	☐ Chest Pain	☐ HIV	☐ Fever Blisters	☐ Neck Problems
☐ Heart Disease	☐ Diabetes	☐ Seizures	☐ Dry Eyes	☐ Sleep Apnea
				☐ Use CPAP/BPAP

Other Major Illnesses:

Medications: Name	Reason for Taking	Frequency/Dose

Do you take ANY Diet Pills, Natural Herbs or Health Food Supplements? If Yes, What: _____

_____

_____

Allergies and Reactions to Medication? _____

_____

Previous Surgeries: _____

_____

_____

Have you or anyone in your family had complications from anesthesia? If Yes, please explain: _____

_____

_____

Has anyone in your family had breast cancer before the age of 50? If Yes, please explain: _____

_____

Have you been on ANY steroids in the last year? If Yes, please explain: _____

_____

Do you take asprin on a regular basis?	☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No
Do you have excessive bleeding or bruising?	☐ Yes	☐ No	Do you have any teeth that are:	☐ Loose	☐ Fragile
Do you use any Tobacco products?	☐ Yes	☐ No		☐ Capped	☐ False

Signature	Date