

HEALTH HISTORY

Patient's Name _____ Current Height _____ Weight _____ (For Peds) Birth Weight _____

Have you had or do you currently have ...	Yes	No	Notes	Have you had or do you currently have ...	Yes	No	Notes
Cancer?				Swollen ankles, arthritis or joint disease?			
Radiation therapy/chemotherapy?				Stomach ulcers?			
Rheumatic fever?				Contagious diseases?			
Heart murmur/Heart disease?				HIV, AIDS?			
High blood pressure?				Problems of the immune system?			
Chest pain, angina?				Mental health problems/psychiatric treatment?			
Heart attack(s)?				Drugs (marijuana, cocaine)?			
Bronchitis, chronic cough, pneumonia?				Alcoholic beverages?			
Asthma, hay fever, or sinus problems?				Eye disease/glaucoma?			
Tuberculosis?				Are you pregnant?			
Difficulty breathing, emphysema?				Pain or clicking of jaws when eating?			
Do you smoke?				TMJ problems?			
Bleeding tendency (abnormal bleed)?				Snoring or sleep disturbance?			
Jaundice, hepatitis or liver disease?				Hearing loss?			
Frequent headaches?				Anemia/sickle cell?			
Convulsions, epilepsy, seizures?				Problems with anesthesia?			
Stroke?				Malignant hyperthermia?			
Thyroid trouble?				Cerebral palsy?			
Diabetes?				Delayed development?			
Are you on dialysis?				Osteoporosis/Osteopenia?			
Kidney trouble?				Other problems not listed?			
Allergies (food/medicine)?				Surgery?			
Please List				Please List			

Medications? Please List _____

Birth History:

1. Did the child's mother have any problems during pregnancy? _____
2. Was the baby delivered via cesarean section? If so, why? _____
3. Was your child premature? How many weeks? _____
4. Did your child have to stay in ICU? How long? _____

Signature _____ Date _____