HEALTH HISTORY

Place patient label here

Today's Date: ________________________
Reason for visit: ________________________

Please tell us about your health history: (check all that apply)

CARDIAC/HEART:
- Bleeding problems (please describe): ______________________
- Heart attack? Date: _____________
- High blood pressure
- High cholesterol
- Irregular heart beat
- Valve problems
- Pacemaker
- Other circulation issues? _____________

RESPIRATORY/LUNGS:
- Asthma
- COPD
- Bronchitis (chronic)
- Pneumonia (chronic)
- Sleep apnea (CPAP/BIPAP)
- Other breathing problems? ______________

NEUROLOGIC/COGNITIVE/MEMORY:
- Head/brain injury
- Seizures
- Forgetfulness/memory loss
- Alzheimer's
- Dementia

EYES/EARS/NOSE/THROAT:
- Blurred vision
- Glaucoma
- Blindness
- Hearing loss
- Chronic sinus problems
- Difficulty swallowing

MUSCLE/JOINT/BONE:
Pain or weakness/numbness in:
- Arms
- Back
- Hands
- Feet
- Shoulder(s)
- Neck

STOMACH/BOWELS/GI:
- Previous colon polyps
- Hemorrhoids
- Diverticulosis
- Ulcers
- Rectal bleeding
- GERD/acid reflux
- Other: ____________

CHRONIC ILLNESSES:
- Diabetes
- Thyroid disease
- Kidney disease
- Liver disease: Hepatitis? YES NO
- Depression/psychiatric disorder
- HIV +

PREVIOUS SURGERIES/PROCEDURES:
Type: ___________________ Year:_________
Type: ___________________ Year: _________
Type: ___________________ Year: _________
Type: ___________________ Year: _________
Type: ___________________ Year: _________
Type: ___________________ Year: _________

Do you have any metal implants in your body? YES NO

Do you smoke? YES NO Qty: _________
Do you drink alcohol? YES NO Qty: _________
Any recreational drug use? YES NO Type: ________

MEDICATIONS (this includes vitamins and herbal supplements)
Please list name, how often you take it and mg/strength. Be as thorough as possible:
____
____
____
____
____
____
____
____

Do you frequently take Aspirin, Motrin, Ibuprofen, Advil or Aleve? YES NO

OTHER HEALTH ISSUES: (please describe with dates, if possible)
Have you recently been ill with a fever? YES NO
Have you ever had or been exposed to tuberculosis? YES NO
Have you ever had an infection that was difficult to treat, even with antibiotics?
If yes, please describe: ________________________________ YES NO
Have you ever been diagnosed with cancer? YES NO
*If yes, what type:*____
Are there any other health issues/concerns you think we should know about?
Please describe: ____

HAVE YOU EVER HAD SEDATION BEFORE? YES NO
Have you experienced any problems with sedation in the past? YES NO
If yes, please describe: ____
____

Signature of patient:

____ Date: _________

Signature of reviewing nurse:

____ Date: _________