HEALTH HISTORY

Name_____

Age_____Date of Birth_____

Purpose of this appointment_____

Circle your present health condition

Excellent Good Fair Poor

Are you presently under the care of a physician? _____

If yes, for what condition? _____

Have you ever been hospitalized or had a serious illness? _____

If yes, please explain _____

Have you ever had excessive bleeding following an extraction or do cuts take longer to heal than previously? _____

Do you have any allergies? _____

If yes, to what? _____

Are you presently taking any medications? _____

If yes, please list _____

(Women) Are you pregnant? _____ If yes, please give due date _____

Do you presently have or have you ever had:

	YES	NO		YES	NO
Tire easily	____	____	Rheumatic Fever	____	____
Marked wt. Change	____	____	Heart Murmur	____	____
Persistent fever	____	____	Chest pain/discomfort	____	____
Night sweats	____	____	Heart Attack	____	____
Frequent nose bleeds	____	____	Swelling of ankles	____	____
Sinus problems	____	____	Heart surgery	____	____
Stroke	____	____	High Blood Pressure	____	____
Epilepsy/Convulsions	____	____	Congenital heart disease	____	____
Psychiatric treatment	____	____	Arthritis/ rheumatism	____	____
Numbness	____	____	Artificial joints	____	____
Dizziness/Fainting	____	____	Hepatitis	____	____
Tuberculosis	____	____	Jaundice	____	____
Emphysema	____	____	Ulcers	____	____
Asthma	____	____	Kidney disease	____	____
Hay fever	____	____	Venereal disease	____	____
Persistent cough	____	____	Bruise easily	____	____
Family history of Diabetes	____	____	Blood transfusion	____	____
Radiation therapy	____	____	AIDS	____	____
Tumors or growths	____	____	HIV Positive	____	____
Cancer	____	____	Thyroid condition/goiter	____	____
Migraine headaches	____	____	Use tobacco	____	____

Are there any other diseases, condition or problem not listed above that you think we should know about?

If yes, please explain _____

Physician's name_____ Phone _____

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Joan K. Knuth or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature **Date**