HEALTH HISTORY

NAME _____

Please answer the following questions and circle 'Yes' or 'No' when appropriate. All responses will be kept strictly confidential.

1) Name of your Physician_____
2) Date of your last physical Examination_____

3) Are you allergic to ANY medication or substance? Specify_____ YES NO

4) Are you taking ANY prescription medications? Specify _____ YES NO
_____

5) Do you have or did you ever have any of the following:
a) Heart Murmur b) Heart Attack c) Rheumatic Fever
d) Open Heart Surgery e) Joint Replacement_____ YES NO

6) Do you get short of breath when you lie down?_____ YES NO

7) Do you ever get chest pains or heaviness in your chest?_____ YES NO

8) Do you have a blood pressure problem? Specify high or low_____ YES NO
9) Do you have a thyroid condition? Specify_____ YES NO

10) Do you have any form of lung disease? Specify_____ YES NO

11) Do you have or did you ever have tuberculosis?_____ YES NO

12) Did you ever have any form of Liver disease or Hepatitis?_____ YES NO

13) Did you ever have any form of Venereal Disease? Specify_____ YES NO

14) Were you ever diagnosed as having the HIV virus or AIDS?_____ YES NO

15) Do you have any form of kidney disease? Specify_____ YES NO
16) Do you have any blood disorders (ie. Anemia)? Specify_____ YES NO

17) Do you have **ANY** condition not listed? Specify_____ YES NO

WOMEN
18) Are you taking birth control pills?_____ YES NO
19) Are you pregnant? _____ YES NO

Signature *(Patient or Guardian)*_____ *Date*_____