HEALTH HISTORY

Have you suffered from (mark a C for CURRENT or P for PAST):

\_\_\_\_ Headaches \_\_\_\_ Neck Pain \_\_\_\_ Joint Stiffness

\_\_\_\_ Arm Pain \_\_\_\_ Tingling Arms \_\_\_\_ Numbness Arms

\_\_\_\_ Leg Pain \_\_\_\_ Tingling Legs \_\_\_\_ Numbness Legs

\_\_\_\_ Cold Hand/Feet \_\_\_\_ Diabetes/Tuberculosis \_\_\_\_ Arthritis

\_\_\_\_ Hip pain \_\_\_\_ Shoulder pain \_\_\_\_ Artificial Bones/Joints

\_\_\_\_ Upper Back Pain \_\_\_\_ Lower Back pain \_\_\_\_ Loss of smell

\_\_\_\_ Sinus/Allergy \_\_\_\_ Asthma/Emphysema \_\_\_\_ Ulcers/Colitis

\_\_\_\_ Heart Attack/Stroke \_\_\_\_ Heart Defect \_\_\_\_ Pacemakers

\_\_\_\_ Cancer \_\_\_\_ Chemotherapy \_\_\_\_ High/Low Blood Pressure

\_\_\_\_ Shingles \_\_\_\_ Kidney Problems \_\_\_\_ Painful Urination

\_\_\_\_ HIV/AIDS \_\_\_\_ Psychiatric Problems \_\_\_\_ Shortness of Breath

\_\_\_\_ Chest Pain \_\_\_\_ Alcohol/Drug Abuse

\_\_\_\_ Dizziness/Fainting/Seizures/Epilepsy

Please list any other serious medical conditions/surgeries you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any past serious accidents (with dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Women: Are you taking Birth Control? Yes \_\_\_\_ No \_\_\_\_

 Are you pregnant? Yes \_\_\_\_ No \_\_\_\_

* Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the billing manager. If account is not paid within 90 days of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account balance.
* I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_