Health History

Patient Name_____ Birth date_____

Do you have or have you had any of the following? (please check)

□ Acid Reflux
□ Allergies
□ Alzheimer's/Dementia
□ Anemia
□ Anxiety
□ Arthritis
□ Asthma
□ Auto Immune Disease
□ Breathing Problems
□ Bleeding Tendencies
□ Carotid Artery Disease
□ Colitis
□ Crohn's
□ Depression
□ Emphysema
□ Heart Attack
□ Heart Condition
□ Hepatitis
□ Herpes S Virus
□ High Blood Pressure
□ High Cholesterol
□ Irregular Heart Beat
□ Kidney Disease
□ Liver Disease
□ Lupus
□ MRSA
□ Multiple Sclerosis (MS)
□ Myasthenia Gravis
□ Migraines
□ Parkinson's
□ Prostate
□ Rheumatoid Arthritis
□ Rosacea
□ Sarcoid
□ Sinus
□ Sjogren's
□ Seizures
□ Shingles
□ Stroke
□ Thyroid Hyper/Hypo
□ Tuberculosis
□ Wegner's

Are you Diabetic? □ Yes □ No If YES please fill out this section:

How many years? ____ □Type I □ Type II How do you control it? □ Diet □ Medication □ Insulin
Average blood sugar reading? _____ Your last Hemoglobin A1C reading (if known)? _____
Do you see a specialist for your condition? □ No □ Yes If so, who? _____

Have you ever been diagnosed with cancer: □ Yes □ No If yes please Specify _____

MEDICATION	DOSAGE	WHAT IS THE MEDICATION USED FOR