HEALTH HISTORY

YES	NO	DISEASES	YES	NO	DISEASES
		Irregular Heart Beat			**Prostate Problems**
		Congestive Heart Failure			**Liver Disease, Type:**
		Heart Attack			**Hepatitis? When?**
		Stroke			**Gallstones**
		Heart Murmur			**Arthritis? Osteo or RA**
		Pace Maker (chest pain?)			**Fibromyalgia**
		High Blood Pressure			**Gout**
		High Cholesterol			**Thyroid Problems**
		Diabetes / High Blood Sugar			**Cancer? Type:**
		Asthma			**Epilepsy / Seizures**
		Emphysema / Chronic Bronchitis			**Rheumatic Fever**
		Sleep Apnea			**Muscle Weakness**
		Do you wear oxygen?			**Anemia / Low Blood**
		Tuberculosis			**Skin Diseases? Type:**
		Blood Clot in Leg			**Glaucoma**
		Blood Clot in Lung			**Hearing Aid**
		Bleeding Problems, Type:			**Claustrophobia**
		Blood Transfusion			**Depression**
		Ulcers in Bowel / Stomach			**Anxiety**
		Bleeding from Bowels			**Other:**
		Kidney Disease, Type:			
		Kidney Stones			

When was you most recent physical?____________________ Labs?_________________ EKG?_________________

With which provider?____

Please list all treating physician names and phone numbers:

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Patient Signature: ____ **Date:** ____________________