PATIENT NAME: ____________________

INITIAL DATE: ____________________

UPDATE: ____________________

UPDATE: ____________________

HEALTH INFORMATION

Personal Physician: ____________________
Name Address

YES NO

❑ ❑ 1. Have you been hospitalized within the past 2 years? For what? ____________________

❑ ❑ 2. Are you currently being treated by a physician? For what? ____________________

❑ ❑ 3. Are you currently taking any medicines or drugs? What? ____________________

❑ ❑ 4. Are you allergic to any drugs? What? ____________________

❑ ❑ 5. Are you allergic to any metals? What? ____________________

❑ ❑ 6. Are you allergic to any type of food? What? ____________________

❑ ❑ 7. Have you ever had a skin rash or other reaction to metal jewelry? To what? ____________________

❑ ❑ 8. Do you bleed excessively upon injury?

❑ ❑ 9. Women: Are you pregnant?

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD

A. AIDS/HIV Positive
B. Arthritis
C. Asthma
D. Cancer
E. Diabetes
F. Epilepsy
G. Glaucoma
H. Heart Murmur
I. Heart Problem
J. Hepatitis
K. High Blood Pressure
L. Jaundice
M. Kidney Problems
N. Low Blood Pressure
O. Rheumatic Fever
P. Sexually Transmitted Diseases
Q. Stroke
R. Tuberculosis
S. Joint Replacement
T. Other Diseases

If you circled either I or S describe conditions:
____
____

Signature:	Reviewed by:	Date: