Patient Name:				Date:		
		Health History	v			
Medical Health History:			,			
Describe your present heal	th Excellent	Good Fair	Poor			
2. List your current Physician						
,						
3. Date of your last physical e			• •			
4. Are you aware of any chan		•		Yes		
5. Have you been hospitalized for illness or surgery in the past two years?				Yes		
6. Have you been under a medical doctor's care during the past two years?				Yes		
	7. Have you ever had excessive bleeding that required special treatment?					
				Yes		
8. Is there any history of diabetes in your family?				Yes		
9. Do you smoke? No Yes How much?				<u> </u>		
10. Do you use smokeless tobacco? No Yes How much?				How long?		
10. Are you taking blood thinn	0 1					
11. List all medications you are	e now taking (inclu	de over the counter)				
List all medications you are all	lergic to:					
Allergic to latex/metals?						
Indicate which of the following	ng you have had o	r presently have, circle yes	s or no:			
A Nervous Person	No/Yes	Epilepsy or Seizures	No/Yes	Liver Disease	No/Ye	
AIDS	No/Yes	Fainting or Dizzy Spells	No/Yes	Low Blood Pressure	No/Ye	
Allergies or Hives	No/Yes	Frequent Headaches	No/Yes	Persistent Cough	No/Ye	
Anemia	No/Yes	Frequent Thirst/Urination	No/Yes	Psychiatric Care	No/Ye	
Angina	No/Yes	Glaucoma	No/Yes	Radiation Treatment	No/Ye	
*Arthritis Rheumatism	No/Yes	Hay Fever	No/Yes	Rheumatic Fever	No/Ye	
*Artificial Joint (Knee, Hip)	No/Yes	Heart Disease or Attack	No/Yes	Scarlet Fever	No/Ye	
*Artificial Heart Valve	No/Yes	Heart Murmur	No/Yes	Shortness of Breath	No/Ye	
Asthma	No/Yes	Heart Pacemakers	No/Yes	Sinus Trouble	No/Ye	
Blood Transfusions	No/Yes	Heart Surgery	No/Yes	Stroke	No/Ye	
Birth control pills	No/Yes	Heart Trouble	No/Yes	Taking hormone med.	No/Ye	
Cancers or Tumors	No/Yes	Hemophilia	No/Yes	Thyroid Disease	No/Ye	
Chemotherapy	No/Yes	Hepatitis	No/Yes	Tuberculosis	No/Ye	
Congenital Heart Lesions	No/Yes	High Blood Pressure	No/Yes	Ulcers	No/Ye	
Diabetes	No/Yes	HIV Positive	No/Yes	Weight Loss/Gain	No/Ye	
Drug/Alcohol Addict	No/Yes	If female, are you pregnate				
Emphysema	No/Yes	Kidney or Bladder Troub	le No/Yes			
* If yes to any of starred cond Do you have any medical cond Explain:	litions or diseases w	ve should know about? No/				
Do you have any medical cond Explain: To the best of my knowledge,	litions or diseases w	we should know about? No/		nges in my health or medicines	 s, I wil	
inform the Doctor on or before Patient's Signature:			Date:			
		_	.			
Doctor's Signature:			Date:			

CS Health History Update Revised/Altman AMK Management and Consulting Inc.