

# HEALTH HISTORY

Current Medical Treatment	Allergies	Medications	
<input type="checkbox"/> Insulin Resistant <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Respiratory/Asthma <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Circulatory <input type="checkbox"/> Anemia/Bleeding <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Diabetes/Kidney <input type="checkbox"/> Herpes <input type="checkbox"/> Thyroid/Hormonal <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Smoke <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Cancer/Tumor <input type="checkbox"/> Radiation/Chemo <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Fatigue <input type="checkbox"/> Swelling <input type="checkbox"/> Are you pregnant? <input type="checkbox"/> Or maybe pregnant?	<input type="checkbox"/> Ulcers/Digestive <input type="checkbox"/> Migraine/Headaches <input type="checkbox"/> Epilepsy/Fainting <input type="checkbox"/> Glaucoma/Visual <input type="checkbox"/> Mental/Neural <input type="checkbox"/> Immunocompromised <input type="checkbox"/> HIV <input type="checkbox"/> Alcoholism/Addiction <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> TMJ <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Murmur/Defect <input type="checkbox"/> Pacemaker <input type="checkbox"/> Heart Attack/Stroke <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Prosthetic Implant <input type="checkbox"/> Any Transplant <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Arthritis <input type="checkbox"/> No Medical Condition	<input type="checkbox"/> Penicillin <input type="checkbox"/> Antibiotics <input type="checkbox"/> Aspirin <input type="checkbox"/> Tylenol <input type="checkbox"/> Codeine <input type="checkbox"/> Narcotics <input type="checkbox"/> Local Anesthesia <input type="checkbox"/> Latex <input type="checkbox"/> Valium/Tranquil. <input type="checkbox"/> Nitrous <input type="checkbox"/> Food <input type="checkbox"/> Bleach <input type="checkbox"/> Iodine/Seafood <input type="checkbox"/> Sulfa  <input type="checkbox"/> No Allergies	<input type="checkbox"/> Antibiotic <input type="checkbox"/> Pain Medicine <input type="checkbox"/> Heart Medicine <input type="checkbox"/> Aspirin <input type="checkbox"/> Cortisone/Steroids <input type="checkbox"/> Blood Thinner <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Hormone <input type="checkbox"/> Thyroid <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> Insulin <input type="checkbox"/> Ulcer/Nexium <input type="checkbox"/> Bone Related <input type="checkbox"/> Antidepressants <input type="checkbox"/> Tagament <input type="checkbox"/> Herbal Supplements <input type="checkbox"/> Insulin Resistance <input type="checkbox"/> Cholesterol  <input type="checkbox"/> No Medications

Notes

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The information above is correct.

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Name

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Date