Name:_____ Date:_____

Acct #:_____

HEALTH HISTORY FORM - PFSH

DOB:_____ M / F Height:_____ Weight:_____ BMI:_____ R / L Handed Occupation:_____

Do you have any **ALLERGIES** or **REACTIONS** to **Latex, Iodine** or any **Medication**? ___**YES**, (please list) or ___**NO**, I have none of these allergies.

1. 3. 5.

2. 4. 6.

List all **MEDICATIONS/Herbs/Vitamins and Supplements** that you are **currently taking**:

☐ Check Box if separate list has been provided 3. 6.

1. 4. 7.

2. 5. 8.

List all **SURGERIES** that you have had **with approximate dates** of each surgery:

1. 3. 5.

2. 4. 6.

MEDICAL HISTORY

	NO	YES			NO	YES
High Blood Pressure	____	____		Asthma/Emphysema	____	____
Heart Attack/Coronary Artery Disease	____	____		Bleeding Disorder/Anemia	____	____
Irregular Heart Beat	____	____	If yes, do you have a **Pacemaker**? Yes / No	Intestinal Bleeding/Ulcer	____	____
Stroke/Paralysis	____	____		**Hypo**thyroid	____	____
Diabetes	____	____		**Hyper**thyroid	____	____
Kidney Failure/Disease	____	____	If yes, are you on **Dialysis**? Yes / No	Seizures	____	____
Rheumatologic Condition	____	____		TB	____	____
Hepatitis/Liver Disease/HIV	____	____		Reaction to Anesthesia	____	____
MRSA	____	____		Other:_____	____	____
Cancer	____	____	If yes, **Type of Cancer**/Description:_____			

FAMILY HISTORY

	NO	YES		NO	YES		NO	YES		NO	YES		NO	YES	
Stroke	___	___	Heart Attack	___	___	Diabetes	___	___	Reaction to Anesthesia	___	___	Bleeding Disorder or Anemia	___	___	Cancer ___ ___ Type:_____

SYSTEMS REVIEW - Have you **recently** had problems with any of the following?

	NO	YES	DESCRIPTION (**If Yes**, provide a description and indicate if condition is resolved)
Cold/Flu	____	____	_____
Eye/Ear	____	____	_____
Intestinal	____	____	_____
Heart	____	____	_____
Breathing	____	____	_____
Skin	____	____	_____
Nerve	____	____	_____
Urinary	____	____	_____
Bleeding	____	____	_____
Depression/Anxiety	____	____	_____

SOCIAL HISTORY

Do you **SMOKE**? ____**NEVER DID** or ____**QUIT**, I have not smoked since: _____ or ____**YES**, I smoke _____cigarettes per day
Do you use **RECREATIONAL DRUGS** (including Marijuana)? ____**NO** or ____**YES**
Do you drink **ALCOHOL?** ____**NO** or ____**YES**, number of drinks per day_____, week_____, month_____

What sport(s) do you participate in or activities do you do for **EXERCISE**? _____

High School Attended:_____ College Attended:_____