

# HEALTH INFORMATION

Yes No

Has there been any change in your general health within the past year?

If yes please describe: \_\_\_\_\_

Are you currently under the care of a physician?

If yes, please explain: \_\_\_\_\_

Have you had any serious illnesses, surgeries, or hospitalizations?

If yes, please explain: \_\_\_\_\_

Do you have or have you had any of the following: (Please circle all that apply)

- Rheumatic fever    Congenital heart disease    Cardiovascular disease    Artificial or replacement heart valves  
Pacemaker    Sinus problems    Asthma or hay fever    Hives or skin rash    Fainting spells    Seizures  
Heart trouble    Heart attack    Heart murmur    Arteriosclerosis    High or low blood pressure    Stroke  
Hepatitis    Jaundice    Liver disease    Diabetes    Cancer/Tumor    Arthritis    Rheumatism    Artificial joints  
Digestive problems    Stomach disorders    Kidney trouble    AIDS    HIV    STD    Herpes    TB  
Bleeding problems    Epilepsy    Bruise easily    Anemia    Radiation, chemotherapy or other cancer treatment  
Glaucoma    Alcoholism    Substance abuse    Blood transfusion    Persistent cough or cough up blood

If you circled any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_

Please list any allergies (including medications, latex, or metals) that you have: \_\_\_\_\_

\_\_\_\_\_

Please list any medications (including vitamins and herbs) you are taking: \_\_\_\_\_

\_\_\_\_\_

Do you drink alcohol or use tobacco products? If so, how much? \_\_\_\_\_

Do you have any disease, condition or health problem not listed above. If so, please explain below:

\_\_\_\_\_

Name and telephone # of your medical doctor: \_\_\_\_\_

What is the approximate date of your last visit to a medical doctor: \_\_\_\_\_

## WOMEN:

Are you pregnant or nursing? \_\_\_\_\_ Taking birth control \_\_\_\_\_ or hormone replacement therapy? \_\_\_\_\_