HEALTH HISTORY

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Are you in good health at the present time? Yes:_____ No:_____
If answer is no, please explain:_____

Have you been under the care of any physician for any medical or surgical condition in the last five years? If so, please list physician and condition treated for:

_____
_____

Please list all surgery, including cosmetic surgery that you have had including dates:

_____
_____
_____

Please list medications that you are presently taking, including Aspirin or Ibuprofen. Please include dosages, frequency and the reason for taking the medications:

_____
_____

Do you have any known allergies? If so, please list:_____
Are you presently under psychological or psychiatric care? If so, please state therapist's name and length of treatment:_____
Do you smoke? If so, how many packs per day? _____
Do you drink alcohol? If so, approximately how much? _____
For women: Is there is a possibility that you may be pregnant? _____
When was your last general physical exam? _____

Do you suffer from any of the following?	YES	NO
*Asthma, chronic bronchitis or other lung problem?	___	___
*Heart disease, including angina, arrhythmias or prior heart attacks?	___	___
*High blood pressure?	___	___
*Diabetes?	___	___
*Kidney disease?	___	___
*Hepatitis or other liver disease?	___	___
*Peptic ulcers?	___	___
*Ulcorative colitis or other intestinal problems?	___	___
*Lupus, scleroderma or other autoimmune disease?	___	___
*Bleeding disorders?	___	___
*HIV or Herpes (fever blisters), or other communicable diseases (Please Circle)	___	___
*Other significant medical problems?	___	___

*Are there any other Medical or non-Medical conditions that we should know about in order to better care for you?

_____
_____
_____