Health History

Name (Please Print): ____

1. Date of last Medical Exam: ______________ ***Medical Doctor's Name:*** ______________ ***Phone:*** ____________

2. Were You hospitalized during the past two years? YES / NO Explain ___________________________________

3. Were you under the care of a Medical Doctor in the last 2 years? YES / NO Explain: ______________________

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4. Are you allergic to *(i.e.: itching, rash, swelling of hands, feet, or eyes)* or made sick by PENICILLIN, ASPIRIN, CODEINE, LOCAL ANESTHETICS, LATEX, METALS, or any other medication? YES / NO Explain:

5. Circle any of the following that you have had or Presently Have:

Heart Disease / Attack
Angina Pectoris
High Blood Pressure
*Mitral Valve Prolapse
*Heart Murmur
*Rheumatic Fever
*Congenital Heart Lesions
*Artificial Hip, Knee, or other Joint
*Any Type of Impant
*Any Type of Transplant
Heart Pace Maker
Ever taken Phen Phen? Yes no
Cancer (Type:______________)

HIV, AIDS, ARC
Kidney Disorders
Use of Tobacco Products
Emphysema
Tuberculosis
Asthma
Jaundice
Diabetes
Radiation Treatment
Chemotherapy
Arthritis
Fainting or Dizzy Spells
Stroke
Epilepsy or Seizures

Alcoholism
Drug Addiction
Glaucoma
Cortisone
Hepatitis (Type:______)
Liver Disease
Allergies or
Excessive Bleeding
Bruise Easily
Anemia
Herpes
Psychiatric Treatment
Cold Sores

****Antibiotic Pre-medication may be required prior to your appointment.***

6. *WOMEN ONLY*: Pregnant: YES/NO **Nursing?** YES/NO **Taking Birth Control Pills?** YES/NO

7. Please list ALL medications you are currently taking (including over the counter medications, vitamins, or herbal remedies):

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To the best of my knowledge, all of the information on this form is true and correct. If there is any change in my health, or my medications, I will inform the doctor prior to any treatment.

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I understand that my health history information will be used as necessary for diagnosis or treatment by Dr. Fuchs. I understand that antibiotics may reduce the effectiveness of birth control pills.

PATIENT SIGNATURE: ____ **DATE:** ______________

I **have reviewed my medical history and the above (including any changes) is accurate:** Date: ___________ Initials: _______ Date: ___________ Initials: _______ Date: __________ Initials: _____