Patient Health History Update

## Patient Information

Name:____________________ Birth Date:__________ Age:______ Sex ❑ M ❑ F

Street address:____________________ City:__________ State:______ Zip:______

Soc. Sec #:__________ Home Phone:__________ Cell Phone:__________

Work Phone:__________ Email:____________________ Marital Status:__________

Employer:____________________ Occupation:____________________

Emergency Contact__________ Relation to Patient__________ Phone__________

## Responsible Party Information

❑ **Check here if the same Responsible Party that we currently have on File:____________________**

Name____________________ Birth Date__________

Relation to Patient__________ Phone__________ Soc. Sec. #__________

Address (if different from patient's)____________________

Employer__________ Occupation__________ Work Phone__________

## Insurance Information

❑ **Check here if insurance is still the same Insurance that we currently have on File:____________________**

Policy Holder's Name__________ Relation to Patient__________ Birth Date__________

Insurance Company Name__________ Policy Holder's Employer's Name:__________

Soc. Sec. #__________ Subscriber #__________ Cell Phone__________

Do you have secondary insurance? ❑ Yes ❑ No

## Medical History

Any changes to your general health problems? ❑ Yes ❑ No Please specify____________________

Are you currently under physician's care? ❑ Yes ❑ No Reason____________________

Name and phone of physician____________________

Are you currently taking any drugs or medications? ❑ Yes ❑ No Please list____________________

________________________________________

**Are you allergic to:** ❑ Penicillin ❑ Codeine ❑ Latex ❑ Other

**Are you pregnant?** ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

**Check X if you have any of the following:**

| | | | |
|---|---|---|---|
| ❑ Anemia | ❑ Blood Disorders | ❑ Epilepsy | ❑ Prolonged Bleeding |
| ❑ Cortisone Treatments | ❑ Cancer | ❑ Heart Murmur | ❑ Radiation Treatment |
| ❑ Hepatitis | ❑ Chemical Dependency | ❑ Heart Problems | ❑ Respiratory Disease |
| ❑ Arthritis/Rheumatism | ❑ Chemotherapy | ❑ HIV/AIDS | ❑ Rheumatic Fever |
| ❑ Artificial Heart Valves | ❑ Scarlet Fever | ❑ Kidney Disease | ❑ Shortness of Breath |
| ❑ Artificial Joints | ❑ Healing complications | ❑ Liver Disease | ❑ Stroke |
| ❑ Asthma | ❑ Diabetes | ❑ Mitral Valve Prolapse | ❑ Thyroid Problems |
| ❑ High Blood Pressure | ❑ Pacemaker | ❑ Tuberculosis | |

**Signature Of Patient/Legal Guardian**____________________ **Date**__________