HEALTH HISTORY FORM FOR PATIENTS OF DR. CHANG

Date _____

Name_____ **Date of Birth** _____

Address _____ **Telephone** _____

Business Address_____ **Business Phone**_____

Soc. Sec. No. _____

PATIENT MEDICAL HISTORY

Physician _____**Office Phone**_____ **Home Phone**_____

Approximate date of last physical examination _____

	YES	NO
1. Are you taking aspirin or any blood thinners ?	☐	☐
2. Are you under any medical treatment now?	☐	☐
Please List: _____		
_____		
_____		
3. Have you had any major operations?	☐	☐
Please List: _____		
_____		
_____		
4. Have you ever had any adverse reaction to any metals?	☐	☐
5. Have you ever had any adverse reaction to latex or any rubber products?	☐	☐
6. Have you ever had a serious accident involving head injuries ?	☐	☐
7. Have you had any adverse response to any drugs including penicillin ?	☐	☐
8. Has a physician ever informed you that you had: Heart Ailment?	☐	☐
9. High Blood Pressure?	☐	☐
10. Have you ever been told you have a heart murmer or mitral valve prolapse ?	☐	☐
11. Respiratory Disease?	☐	☐
12. Diabetes?	☐	☐
13. Frequent urination, thirst or hunger?	☐	☐
14. Rheumatic Fever?	☐	☐
15. Rheumatism or Arthritis?	☐	☐
16. Tumors or Growths?	☐	☐
17. Any Blood Disease?	☐	☐
18. Any Liver Disease?	☐	☐
19. Any Kidney Disease?	☐	☐
20. Any Stomach or Intestinal Disease?	☐	☐
21. Any Venereal Disease?	☐	☐
22. Tested HIV positive or AIDS Related Complex?	☐	☐
23. Yellow Jaundice or Hepatitis?	☐	☐
24. Do you have night sweats accompanied by weight loss or cough?	☐	☐
25. Are you on a diet at this time?	☐	☐
26. Are you now taking drugs or medications?	☐	☐

Please List: (Name of medication and dose).

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_____

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