



Health History

Date _____

Confidential Record: Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. Dr. Farahmand will use the information you provide in her decision regarding your care.

Patient Name: _____

	Last	Yes	No	First	Middle	
1. Have you ever had:				5. Family Physician		_____
Heart disease		<input type="checkbox"/>	<input type="checkbox"/>			
High Blood Pressure		<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes		<input type="checkbox"/>	<input type="checkbox"/>	6. Are you allergic to:	Yes	No
Epilepsy		<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease		<input type="checkbox"/>	<input type="checkbox"/>	Novacaine	<input type="checkbox"/>	<input type="checkbox"/>
Asthma		<input type="checkbox"/>	<input type="checkbox"/>	Other drugs (list)	_____	
Cancer		<input type="checkbox"/>	<input type="checkbox"/>	_____		
Rheumatic Fever		<input type="checkbox"/>	<input type="checkbox"/>	7. List medications you take:	_____	
Hepatitis		<input type="checkbox"/>	<input type="checkbox"/>	_____		
HIV		<input type="checkbox"/>	<input type="checkbox"/>	_____		
2. Do you Have:		Yes	No	8. Do you smoke?	Yes	No
Shortness of breath		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Dizzy spells		<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many packs per day:	_____	
Swelling of ankles		<input type="checkbox"/>	<input type="checkbox"/>	How many years	_____	
Chest pain		<input type="checkbox"/>	<input type="checkbox"/>	9. Do you consume alcoholic		
Prolonged bleeding		<input type="checkbox"/>	<input type="checkbox"/>	beverages daily	Yes	No
Jaundice		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
3. Do you take:		Yes	No	10. List operations you have had	_____	
Vitamin E		<input type="checkbox"/>	<input type="checkbox"/>	_____		
Blood Thinner Meds		<input type="checkbox"/>	<input type="checkbox"/>	_____		
Heart medications		<input type="checkbox"/>	<input type="checkbox"/>	11. List any medical problem not		
High blood pressure		<input type="checkbox"/>	<input type="checkbox"/>	previously mentioned:	_____	
Diuretics (water pills)		<input type="checkbox"/>	<input type="checkbox"/>	_____		
Aspirin		<input type="checkbox"/>	<input type="checkbox"/>	12. Do you have	Yes	No
4. Do you take or have you		Yes	No	A living will	<input type="checkbox"/>	<input type="checkbox"/>
ever taken		<input type="checkbox"/>	<input type="checkbox"/>	A health care surrogate and /or		
Steroids (cortisone, prednisone)		<input type="checkbox"/>	<input type="checkbox"/>	Power of attorney	<input type="checkbox"/>	<input type="checkbox"/>
				13. Are you currently under psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>
				14. Do you have a psychiatric diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>
				15. Have you ever or are currently taking	<input type="checkbox"/>	<input type="checkbox"/>
				Medication for a psychiatric diagnosis?		