CONFIDENTIAL PATIENT INFORMATION II

(Please Print Legibly)

Patient Name:_____ Initial Date:_____
Update:_____
Update:_____
Update:_____
Update:_____

HEALTH INFORMATION

Personal Physician Name:_____

Personal Physician Address:_____

YES	NO	
☐	☐	1. Have you been hospitalized within the past 2 years? For what?_____
☐	☐	2. Are you currently being treated by a physician? For what?_____
☐	☐	3. Are you currently taking any medicines or drugs? What?_____
☐	☐	4. Have you ever received counseling or excessive use of alcohol and/or prescription drugs?
☐	☐	5. Are you allergic to any drugs? What?_____
☐	☐	6. Are you allergic to any metals? What?_____
☐	☐	7. Have you ever had a skin rash or other reaction to metal jewelry? To what?_____
☐	☐	8. Do you bleed excessively upon injury?
☐	☐	9. Are you pregnant?
☐	☐	10. Do you snore?
☐	☐	11. Do you have morning headaches?

CIRCLE ANY OF THE FOLLOWING CONDITION THAT YOU HAVE HAD

A. AIDS
B. Arthritis
C. Asthma
D. Cancer
E. Diabetes
F. Epilepsy
G. Glaucoma
H. Heart Murmur
I. Heart Problem*
J. Hepatitis
K. High Blood Pressure
L. Jaundice
M. Kidney Problems
N. Low Blood Pressure
O. Nervous Breakdown or Psychiatric Therapy
P. Rheumatic Fever
Q. Sexually Transmitted Diseases
R. Stroke
S. Tuberculosis
T. Other Diseases

PERSON TO BE CONTACTED IN CASE OF EMERGENCY

Name:_____

Address:_____

Telephone: (Home)_____ (Work)_____

SIGNATURE:	REVIEW BY:	DATE: