CONFIDENTIAL HEALTH INFORMATION

(Please complete all areas)

Name:_____ Date:_____

Address:_____ Phone No. _____

Email Address:_____

Date of Birth:_____ Medical Physician's Name:_____

Date of last doctor's visit:_____

Medical History

1. Are you currently under the care of a physician? _____ Explain:_____
   _____
2. Have you been hospitalized or received emergency care in the last two years? _____
   Explain:_____
3. Women:
   - Are you pregnant? ☐ Yes ☐ No Due Date:_____
   - Are you nursing? ☐ Yes ☐ No
   - Have you had a skin reaction to wearing jewelry? ☐ Yes ☐ No
4. **Please list all current medications, including supplements**:_____
   _____
5. **Please list any allergies to any medications or materials (such as metals or latex)**:
   _____
6. **Have you ever had any of the following: Please check all that apply.**

- ○ Anemia
- ○ Angina
- ○ Arthritis
- ○ Artificial Heart Valve
- ○ Artificial Joint Replacement
- ○ Asthma
- ○ Back Problems
- ○ Bacterial Endocarditis
- ○ Blood Disease
- ○ Cancer (type/date)_____
- ○ Chemical (alcohol or drug) dependency
- ○ Chemotherapy (date)_____
- ○ Congestive Heart Failure
- ○ Cough, Persistent
- ○ Diabetes
- ○ Dizziness
- ○ Epilepsy
- ○ Fainting
- ○ Glaucoma
- ○ Head Injuries
- ○ Heart Attack
- ○ Heart Murmur/Mitral Valve Prolapse
- ○ Hepatitis
- ○ High Blood Pressure
- ○ HIV/AIDS
- ○ Kidney Disease
- ○ Liver Disease
- ○ Mental/Psychological Disorders
- ○ Pacemaker
- ○ Radiation Treatment
- ○ Respiratory Disease
- ○ Sexually Transmitted Disease
- ○ Sinus Problems
- ○ Sleep Apnea
- ○ Snoring
- ○ Stroke or TIA
- ○ Tobacco Habit (present)
- ○ Tobacco Habit (past)
- ○ Tuberculosis
- ○ Ulcers
- ○ Other_____

_____ _____

Patient or Guardian Signature Date