HEALTH HISTORY

Are you taking any of the following medications?
□ Nerve Pills □ Pain Killers (including Aspirin) □ Muscle Relaxers
□ Stimulants □ Blood Thinners □ Tranquilizers □ Insulin □ Other_____

IN THE PAST (Prior to today) have you ever had any of the following?

Y	**N**	Heart Attack/Stroke	**Y**	**N**	Heart Surgery/Pacemaker	**Y**	**N**	Heart Murmur
Y	**N**	Congenital Heart Disease	**Y**	**N**	Mitral Valve Prolapse	**Y**	**N**	Artificial Valves
Y	**N**	Alcohol/Drug Abuse	**Y**	**N**	Venereal Disease	**Y**	**N**	Hepatitis
Y	**N**	HIV/AIDS	**Y**	**N**	Shingles	**Y**	**N**	Cancer
Y	**N**	Frequent Neck Pain	**Y**	**N**	Emphysema/Glaucoma	**Y**	**N**	Anemia
Y	**N**	High/Low Blood Pressure	**Y**	**N**	Psychiatric Issues	**Y**	**N**	Rheumatic Fever
Y	**N**	Severe/Frequent Headaches	**Y**	**N**	Kidney Problems	**Y**	**N**	Ulcers/Colitis
Y	**N**	Fainting/Seizures/Epilepsy	**Y**	**N**	Sinus Problems	**Y**	**N**	Asthma
Y	**N**	Diabetes/Tuberculosis	**Y**	**N**	Difficulty Breathing	**Y**	**N**	Chemotherapy
Y	**N**	Lower Back Problems	**Y**	**N**	Artificial Bones/Joints	**Y**	**N**	Arthritis

Please list any other serious medical condition(s) you have or ever had?_____

Please list any prior surgeries and/or hospitalizations:_____

Please list anything that you may be allergic to:_____

Please list any prior injuries and or accidents:_____

Family health history:_____

Do you smoke? □ Yes □ No If Yes, How much?_____ How Long?_____

For women:
Are you taking Birth Control? □ Yes □ No
Are you Pregnant? □ Yes □ No If Yes, How far along?_____ Are you nursing? □ Yes □ No

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made in advance with the Office Coordinator and/or Billing department. If account is not paid within 30 days of the date of service and no financial agreements have been made, you will be responsible for all finance charges, collection agency fees and/or legal fees and any other expenses incurred in collecting your account.
By signing below, you authorize the First Health Medical Center of Fresno, Inc. staff to perform any necessary services needed during diagnosis and treatment. You also authorize the provider and/or managed care organization, to release any information required to process insurance claims. You understand the above information and guarantee this form was completed correctly to the best of your knowledge and understand it is YOUR responsibility to inform this office of any changes to the information you have provided.

Signature_____ Date:_____/_____/_____
□ Adult Patient □ Parent/Guardian □ Spouse