

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

**PERSON TO BE CONTACTED IN CASE OF EMERGENCY**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

<b>SIGNATURE:</b>	<b>REVIEW BY:</b>	<b>DATE:</b>