# Health History

**Personal History** *(Please Print)*

**Name**_____ **SS#**_____ Date of Birth _____/_____/_____
*Last* *First* *M.I.*

| **Have you had? (circle choice)** | **NO** | **Yes** | **Have you had? (circle choice)** | **No** | **Yes** |
|---|---|---|---|---|---|
| Recurrent Headache | | | Asthma | | |
| Eye Problem | | | Epilepsy/Seizures | | |
| Ear Problem | | | Dizziness/Fainting with exercise | | |
| Nose Problem | | | Head Injury/Concussion | | |
| Thyroid Disorder | | | Stomach/Intestinal Problems | | |
| Heart Murmur/Heart Disease | | | Diabetes | | |
| Heart Palpiations | | | Eating Disorder | | |
| High/Low Blood Pressure | | | ADD/ADHD | | |
| Anemia/Sickle Cell | | | Chicken Pox/Immunization | | |
| Bleeding Disorders: Hemophilia/Other | | | Mononucleosis | | |
| Hepatitis | | | Alcohol abuse | | |
| Kidney/Bladder Disorders | | | Drug Abuse | | |
| Pneumonia/Bronchitis | | | Sexual Assault/Violence | | |
| Tuberculosis | | | Emotional Problems-Specify below: | | |
| Seasonal Allergies/Hay Fever | | | Gout | | |
| Surgies/Date: | | | | | |
| Hospitalizations: | | | | | |

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|---|
| **Allergies:** |
| **Medical Allergies:** |
| **Medication/s currently taking:** |

**Any other disease, illness, past surgeries, permanent disabilities, or explanations of any marked concerns from the list above?**

_____

_____

**Are you currently being treated by a health care professional? If yes, explain:** _____

_____

_____

*Return completed forms to:*

**Health Records**
**Pacifica Orthopedics**
**18800 Delaware St. Ste. 1100** **Ph: (714) 841-5333**
**Huntington Beach, CA 92648** **Fax: (714) 841-5303**