HANSEN THERAPEUTIC SERVICES,Inc.

PATIENT HEALTH HISTORY

Patient Name:_____

Do You Have a History of (other than during pregnancy):

Chest pain (angina)?	Yes	No	Shortness of Breath?	Yes	No
Frequent vomiting, nausea?	Yes	No	Dizziness?	Yes	No
Ringing in ears?	Yes	No	Headaches?	Yes	No
Heart disease?	Yes	No	Stomach problems, ulcers?	Yes	No
Heart murmurs or cardiac arrhythmias?	Yes	No	Rheumatic fever?	Yes	No
Stroke, hardening of arteries?	Yes	No	High blood pressure?	Yes	No
TB, asthma, emphysema, other lung diseases?	Yes	No	Hepatitis, other liver diseases?	Yes	No
Heart attack, heart defects?	Yes	No			
HIV positive or AIDS?	Yes	No	Diabetes?	Yes	No
Tumors, cancer?	Yes	No	Pacemaker?	Yes	No
Arthritis, rheumatism?	Yes	No	Artificial joint?	Yes	No
Anemia?	Yes	No			
Thyroid, adrenal disease?	Yes	No			
Surgeries?, If yes, please list below	Yes	No			

_____

WOMEN ONLY

Are you or could you be pregnant? Yes No **If yes, please answer questions below:**

Miscarriages?, If yes how many?_____	Yes	No	Ruptured Membranes?	Yes	No
Premature Labor?	Yes	No	Incompetent Cervix?	Yes	No
Vaginal Bleeding or	Yes	No	Multiple Gestations?	Yes	No
Diagnosis of Placenta Previa?	Yes	No	History of Interuterine Growth Retardation?	Yes	No
Breech Presentation?	Yes	No			

To the best of my knowledge, I have answered every question completely and accurately.

Patient's Signature X_____ Date _____