PATIENT MEDICAL HISTORY

Name:_____Date of Birth:_____

YES NO Are you under medical treatment now? Reason_____
Name of Physician_____Telephone #_____

YES NO Have you had any major operations? If so, what? _____
YES NO Do you have any artificial joints? If so, what and when? _____
YES NO Have you ever had a serious accident involving head or jaw injuries? _____
YES NO Do you have any allergies i.e. latex, penicillin, medications, anesthetic?_____
YES NO Do you use tobacco products, marijuana, vaporizer or smokeless tobacco? _____
YES NO Do you wear hearing aids?
YES NO (Women only) Are you pregnant?____ nursing? ____taking birth control?____
YES NO Are you taking any medication? (Include over-the-counter medications, herbal remedies, vitamins, homeopathic remedies, etc.) Please list with reason for taking.

_____
_____

PAST OR CURRENT MEDICAL CONDITIONS

Please circle if you have ever had:

Abnormal Bleeding/Bruising Easily
AIDS or HIV
Alcohol/Chemical Dependency
Anemia
Angina/chest pains
Arthritis
Asthma Do you carry an inhaler?___
Autoimmune Disease
Cancer Type _____
COPD
Diabetes Type 1 or Type 2
Emphysema
Endocarditis
Epilepsy/Convulsions
Heart attack/heart disease
Heart murmur
Heart valve replacement
Hepatitis/Jaundice Type_____
Herpes (Simplex or Zoster)
High Blood Pressure
History of Eating Disorder
Kidney disease
Low Blood Pressure
Mitral Valve Prolapse
Pacemaker (coated or non-coated)
Radiation Therapy and/or Chemotherapy
Rheumatic Fever
Sinus Problems
Sleep Apnea
Stroke
Thyroid disease/problems
Tuberculosis

Other_____

NOTES/COMMENTS_____

_____

By signing I certify that I have read and understand the above information and have answered to the best of my knowledge

Signature:_____ Date:_____