

MEDICAL HISTORY

Patient Name _____ Date of Birth _____

Most Recent Physical Examination? _____ For? _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD ANY OF THE FOLLOWING: (check yes if so)

- __1. Hospitalization for illness or injury?
 - __2. An allergic reaction to:
 - asprin, ibuprofen, acetaminophen, codeine
 - penicillin
 - erythromycin
 - tetracycline
 - sulfa
 - local anesthetic
 - floride
 - metals (nickel, gold, silver, _____)
 - latex
 - other _____
 - __3. Heart problems, or cardiac stent within the last six months
 - __4. History of infective endocarditis
 - __5. Artificial heart valve, repaired heart defect (PFO)
 - __6. Pacemaker or implantable defibrillator
 - __7. Artificial prosthesis (heart valve or joints)
 - __8. Rheumatic or scarlet fever
 - __9. High or low blood pressure
 - __10. A stroke (taking blood thinners)
 - __11. Anemia or other blood disorder
 - __12. Prolonged bleeding due to a slight cut (INR > 3.5)
 - __13. Emphysema, shortness of breath, sarcoidosis
 - __14. Tuberculosis, measles, chicken pox
 - __15. Asthma
 - __16. Breathing or sleep problems (i.e. sleep apnea, snoring)
 - __17. Kidney disease
 - __18. Liver disease
 - __19. Jaundice
 - __20. Thyroid, parathyroid disease, or calcium deficiency
 - __21. Hormone deficiency
 - __22. High cholesterol or taking statin drugs
 - __23. Diabetes (HbA1c= __)
 - __24. Stomach or duodenal ulcer
 - __25. Digestive disorders (i.e. celiac disease, gastric reflux)
 - __26. Osteoporosis/osteopenia (i.e. taking bisphosphonates)
 - __27. Arthritis, rheumatoid arthritis, lupus
 - __28. Glaucoma
 - __29. Contact lenses
 - __30. Head or neck injuries
 - __31. Epilepsy, convulsions (seizures)
 - __32. Neurologic disorders (ADD/ADHD, prion disease)
 - __33. Viral infections and cold sores
 - __34. Any lumps or swelling in the mouth
 - __35. Hives, skin rash, hay fever
 - __36. STI/STD or HIV/AIDS
 - __37. Hepatitis (type __)
 - __38. Tumor, abnormal growth
 - __39. Radiation therapy
 - __40. Chemotherapy, immunosuppressive
 - __41. Emotional problems
 - __42. Psychiatric treatment
 - __43. Antidepressant medication
 - __44. Alcohol / street drug use
- ARE YOU:**
- __45. Presently being treated for any other illness
 - __46. Aware of a change in your health in the last 24 hours
 - __47. Taking medication for weight management
 - __48. Taking dietary supplements
 - __49. Often exhausted or fatigued
 - __50. Experiencing frequent headaches
 - __51. A smoker, smoked previously, or use smokeless tobacco
 - __52. Often unhappy or depressed
 - __53. FEMALE – taking birth control
 - __54. FEMALE – pregnant
 - __55. MALE – prostate disorders

If yes to any of the above, explain: _____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your treatment: _____

List all medications, supplements, and or vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____