Patient Name: _____ Birth Date: _____ Date Created: _____

MEDICAL HISTORY

1. Are you currently under a Physician's care? **YES NO** If **yes** list Dr.'s name and reason _____

2. Have you ever been hospitalized or had a major operation?

YES NO Please list and date _____

3. Have you ever had a serious neck or head injury? **YES NO**

If **yes** please explain: _____

4. Are you currently taking any medications, pills, drugs? **YES NO**

Please list all medications or provide us a list to copy.

_____

_____

_____

5. Do you take, or have you taken Phen-Fen or redux? **YES NO**

6. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? **YES NO**

7. Are you on a Special Diet? **YES NO**

8. Do you use tobacco?**YES NO** or Controlled Substances?**YES NO**

****Women are you:** Pregnant/Trying to get pregnant? Yes No

On Birth Control? Yes No or Nursing? Yes No

Are Allergic to any of the following: Aspirin __ Metal __ Penicillin __ Codeine __ Acrylic __ Sulfa Drugs __ Latex __ Local Anesthetics __ Other: _____

_____

Do you have, or have you had, any of the following?

Complete on backside →

Patient Name: _____ Birth Date: _____ Date Created: _____

MEDICAL HISTORY

- ☐ **AIDS/HIV Positive**
- ☐ **Alzheimer's Disease**
- ☐ **Anaphylaxis**
- ☐ **Anemia**
- ☐ **Angina**
- ☐ **Arthritis/Gout**
- ☐ **Artificial Joint**
- ☐ **Asthma**
- ☐ **Blood Disease**
- ☐ **Blood Transfusion**
- ☐ **Breathing Problems**
- ☐ **Bruise Easily**
- ☐ **Cancer**
- ☐ **Chemotherapy**
- ☐ **Chest pains**
- ☐ **Cold Sores/ Fever Blisters**
- ☐ **Congenital Heart Disorder**
- ☐ **Convulsions**
- ☐ **Cortisone Meds (Prednisone, Inhalers..etc)**
- ☐ **Diabetes**
- ☐ **Drug Addiction**
- ☐ **Easily winded**
- ☐ **Emphysema**
- ☐ **Epilepsy or Seizures**
- ☐ **Excessive Bleeding**
- ☐ **Excessive Thirst**
- ☐ **Fainting Spells /Dizziness**
- ☐ **Frequent Cough**
- ☐ **Frequent Diarrhea**
- ☐ **Frequent Headaches**
- ☐ **Genital Herpes**
- ☐ **Glaucoma**
- ☐ **Hay Fever**
- ☐ **Heart Attack/Failure**
- ☐ **Heart Murmur**
- ☐ **Heart Pacemaker**
- ☐ **Heart Trouble /Disease**
- ☐ **Hemophilia**
- ☐ **Hepatitis A, B or C**
- ☐ **Herpes**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Hives or Rash**
- ☐ **Hypoglycemia**
- ☐ **Irregular heartbeat**
- ☐ **Kidney problems**
- ☐ **Leukemia**

Patient Name: _____ Birth Date: _____ Date Created: _____

MEDICAL HISTORY

- ☐ **Liver disease**
- ☐ **Mitro-Valve Prolapse**
- ☐ **Parathyroid Disease**
- ☐ **Psychiatric Care**
- ☐ **Radiation Treatment**
- ☐ **Recent Weight Loss**
- ☐ **Renal Dialysis**
- ☐ **Rheumatic Fever**
- ☐ **Rheumatism**
- ☐ **Scarlet fever**
- ☐ **Shingles**
- ☐ **Sickle cell disease**
- ☐ **Sinus Trouble**
- ☐ **Stomach/Intestinal Disease**
- ☐ **Stroke**
- ☐ **Swelling of Limbs**
- ☐ **Thyroid Disease**
- ☐ **Tonsillitis**
- ☐ **Tuberculosis**
- ☐ **Tumor or Growths**
- ☐ **Ulcer**
- ☐ **Venereal Disease**
- ☐ **Yellow Jaundice**
- ☐ **Osteoporosis**
- ☐ **Pain in jaw joints**

Complete Back Side→

Patient Name: _____ Birth Date: _____ Date Created: _____

MEDICAL HISTORY

Do you have or have you ever had any serious illness not listed above? YES NO

If **yes** please list and explain: _____

_____

_____

Comments:

_____

_____

_____

Patient Signature: _____

Date: _____

Turn in to the Front Desk, Thank you*