MEDICAL HISTORY

Welcome! So that we may provide you with the best possible care, please complete this medical history form. All information is completely confidential.

Patient Name: _____ **Date:** _____

Please list any medications you are taking (including regular doses of aspirin and birth control): _____

_____

Physician's Name_____ Phone_____ Date of Last Physical _____

Physician's Address _____ City _____ State_____ Zip _____

Have you been a patient in the hospital within the last five years?.....Yes / No
Have you ever had any type of surgery or operation?.....Yes / No

If yes, please explain_____

Indicate which of the following you have had, or have at present. Please circle "yes" or "no" to each item.

Arthritis.....Yes / No	Organ Transplant .....Yes / No	Thyroid Problems.....Yes / No
Artificial Joints (hip, knee, etc.)...Yes / No	Excessive Urination/Thirst .....Yes / No	Heartburn/GERD.....Yes / No
Heart Attack.....Yes / No	Diabetes (juvenile or adult onset).....Yes / No	Alzheimer's disease .....Yes / No
Heart Surgery.....Yes / No	Gestational Diabetes.....Yes / No	Dry Mouth.....Yes / No
Pacemaker .....Yes / No	Osteoporosis .....Yes / No	Neurological Disorders.....Yes / No
High Blood Pressure.....Yes / No	Cancer or Tumor .....Yes / No	Anxiety/Nervousness.....Yes / No
High Cholesterol.....Yes / No	Radiation Therapy .....Yes / No	Bulimia/Eating Disorder.....Yes / No
Stroke.....Yes / No	Chemotherapy.....Yes / No	Depression.....Yes / No
Emphysema.....Yes / No	Autoimmune Disorder .....Yes / No	Sleep Disorder.....Yes / No
Asthma.....Yes / No	Fibromyalgia .....Yes / No	Frequent Headaches.....Yes / No
Hives.....Yes / No	Kidney Disease.....Yes / No	Migraines.....Yes / No
Anaphylactic Shock.....Yes / No	Tuberculosis.....Yes / No	Sinus Trouble.....Yes / No
Liver Disease.....Yes / No	Epilepsy or Seizures.....Yes / No	Tonsils Removed.....Yes / No
Hepatitis.....Yes / No	Bleeding Disorders.....Yes / No	Canker Sores.....Yes / No
HIV / AIDS.....Yes / No	Glaucoma.....Yes / No	Cold Sores/Fever Blisters.....Yes / No

Do you have or have you had any disease, condition, or problem not listed?.....Yes / No

If yes, please explain_____

Do you or have you ever used tobacco in any form (cigarettes, snuff, chew, cigars)?.....Yes / No

If yes, do you currently use tobacco?.....Yes / No

If yes, how much do you use? _____ At what age did you start?_____

Do you have a Chemical or Alcohol Dependency?.....Yes / No

If yes, please explain_____

Do you have a Family History (Mother, Father, Grandparents, Siblings) of:

Diabetes?.....Yes / No
Heart Problems, High Blood Pressure, or High Cholesterol?.....Yes / No
Periodontal Disease or Tooth Loss?.....Yes / No
Osteoporosis?.....Yes / No

Do you have any allergies.....Yes / No

If yes, (please circle): Penicillin / Sulfa / Aspirin / Ibuprofen / Tetracycline / Codeine / Latex / Nickel / Iodine

Other: _____

Women…are you:

Pregnant (or think you may be pregnant).....Yes / No If yes, when are you due?_____
Nursing?.....Yes / No

Patient/Guardian Signature _____

OVER →