MEDICAL HISTORY

Patient Full Name____Preferred Name_________________Age___
Name of Physician/and their specialty____
Date of recent physical examination____
Your estimate of the overall condition of your general health: □ Good □ Fair □ Poor

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. Hospitalization for illness or injury_______________	□	□
2. Allergy or allergic reactions to: (please check)		
□ latex		
□ aspirin, ibuprofen, acetaminophen (ie. Advil, Tylenol)		
□ penicillin		
□ erythromycin		
□ tetracycline		
□ codeine		
□ local anesthetic		
□ fluoride		
□ metals (gold, stainless steel)		
□ any other medication__________________		
3. heart problems/conditions______________________	□	□
4. heart murmur________________________________	□	□
5. rheumatic fever or scarlet fever_________________	□	□
6. high blood pressure__________________________	□	□
7. low blood pressure___________________________	□	□
8. a stroke____________________________________	□	□
9. artificial joints or heart valves__________________	□	□
10. pacemaker_________________________________	□	□
11. anemia or blood disorder_____________________	□	□
12. prolonged bleeding after cut__________________	□	□
13. shortness of breath_________________________	□	□
14. asthma____________________________________	□	□
15. emphysema_________________________________	□	□
16. tuberculosis (TB)___________________________	□	□
17. breathing or sleeping problems (ie. sinus or snoring)	□	□
18. kidney disease______________________________	□	□
19. liver disease _______________________________	□	□
20. thyroid or parathyroid disease_________________	□	□
21. hormonal deficiency_________________________	□	□
22. high cholesterol_____________________________	□	□
23. diabetes___________________________________	□	□

	YES	NO
24. stomach problems (ie. ulcer)___________________	□	□
25. digestive disorders (ie. gastric reflux)_______________	□	□
26. arthritis___________________________________	□	□
27. glaucoma__________________________________	□	□
28. head or neck injuries________________________	□	□
29. dizziness & fainting_________________________	□	□
30. epilepsy / convulsions (seizures)_________________	□	□
31. neurological problems (ie. memory loss)___________	□	□
32. viral infections & cold sores___________________	□	□
33. any lumps or swelling in the mouth_____________	□	□
34. hives, skin rash, hay fever____________________	□	□
35. venereal disease____________________________	□	□
36. Hepatitis (type___) or jaundice_________________	□	□
37. HIV / AIDS_________________________________	□	□
38. tumor or abnormal growth____________________	□	□
39. radiation therapy___________________________	□	□
40. chemotherapy______________________________	□	□
41. anxiety / depression_________________________	□	□
42. psychiatric treatment________________________	□	□
43. alcohol / drug dependency____________________	□	□
44. Mad Cow Disease, Gerstmann-Straussler-Scheinker Disease or Fatal Familial Insomnial _______________	□	□

ARE YOU:		
45. being treated for any other illness______________	□	□
46. aware of changes in your general health________	□	□
47. on medication for osteporosis / osteopenia_______	□	□
48. often exhausted or fatigued___________________	□	□
49. subject to frequent headaches________________	□	□
50. a smoker or smoked previously_______________	□	□
51. WOMEN - taking birth control pills______________	□	□
52. WOMEN - pregnant__________________________	□	□
53. MEN - prostate disorders_____________________	□	□

Describe any current medical treatment, surgeries or other treatment that you are undergoing/will be undergoing:

____

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

	Drug name	purpose/dosage		Drug name	purpose/dosage
1.	____________________	___________________________	4.	____________________	___________________________
2.	____________________	___________________________	5.	____________________	___________________________
3.	____________________	___________________________	6.	____________________	___________________________

*Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ____ Date ____________________