

# Medical History

Primary Medical Physician: \_\_\_\_\_

Name

Phone

Date of last visit: \_\_\_\_\_ Have you ever had a serious illnesses or operation? ☐ Y ☐ N  
(**With medical physician**) If yes, please describe: \_\_\_\_\_

(Check All That Apply)

Have you ever taken bisphosphonates (Fosamax, Actonel)? ☐

Do you have a history of tobacco use?..... ☐

Under the care of a mental health professional (therapist, counselor, etc)? ☐

Is there anything in your past, such as previous trauma, that would be helpful for us to know today? ☐

Do you have a history of drug **addiction**?

☐Alcohol ☐Meth ☐Marijuana

☐Cocaine ☐Opioids ☐Other\_\_\_\_\_

Are you **allergic** to or have you had any **reactions** to the following?

Local Anesthetics (ex. Novocaine)..... ☐

Penicillin or other Antibiotics..... ☐

Any Metals (ex. nickel, mercury, etc)..... ☐

Sulfa Drugs..... ☐

Sedatives ☐

Iodine ☐

Aspirin ☐

Codeine ☐

Latex Rubber..... ☐

Barbiturates..... ☐

Other\_\_\_\_\_ ☐

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

Autoimmune Disease\_\_\_\_\_ ☐

Heart Attack\_\_\_\_\_ ☐

Rheumatic Fever..... ☐

Bacterial Endocarditis..... ☐

High/Low Blood Pressure..... ☐

Heart Disease..... ☐

Cardiac Pacemaker\_\_\_\_\_ ☐

Heart Murmur..... ☐

Angina/Chest Pain..... ☐

Mitral Valve Prolapse..... ☐

Valvular Replacement\_\_\_\_\_ ☐

Heart Transplant\_\_\_\_\_ ☐

Stroke\_\_\_\_\_ ☐

Blood Transfusion\_\_\_\_\_ ☐

Bleeding Disorder..... ☐

Cortisone Treatment ☐

Anemia..... ☐

Anxiety/Depression.... ☐

Fainting..... ☐

Epilepsy/Seizures..... ☐

Hepatitis A B C ☐

Liver Disease..... ☐

Respiratory Problems ☐

Asthma..... ☐

Emphysema..... ☐

Hay Fever/Allergies... ☐

Tuberculosis..... ☐

Leukemia..... ☐

AIDS or HIV..... ☐

STD..... ☐

Cancer..... ☐

Radiation/Chemo..... ☐

Other\_\_\_\_\_ ☐

Diabetes..... ☐ Type? \_\_\_\_\_

Kidney Disease..... ☐

Thyroid Problems..... ☐

Joint Replacement..... ☐ When? \_\_\_\_\_

Stomach Issues/Ulcer ☐

Glaucoma..... ☐

Psychiatric Care..... ☐

Herpes..... ☐

Jaw Pain..... ☐

Arthritis..... ☐

Osteopenia/porosis..... ☐

Sinus Problems..... ☐

**WOMEN:** Are you pregnant or think you may be pregnant? ☐ Nursing? ☐ Taking birth control meds? ☐

Please list the **Medications** and **Supplements** you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

Provider Signature: \_\_\_\_\_