HEALTH HISTORY

Patient Name:

Last	First	MI

HEALTH HISTORY

☐ AIDS or HIV Infection	☐ Epilepsy	☐ Pacemaker
☐ Alzheimer's/dementia	☐ Fainting Spells or seizures	☐ Persistent swollen glands in neck
☐ Anemia	☐ Gastrointestinal disease	☐ Pre-Med no longer needed
☐ Angina	☐ G.E Reflux/persistent heartburn	☐ Psychiatric care
☐ Anxiety	☐ Glaucoma	☐ Recurrent infections
☐ Arteriosclerosis	☐ Hearing difficulties	☐ Rheumatic fever
☐ Arthritis	☐ Heart attack	☐ Rheumatic heart disease
☐ Artificial Joints	☐ Heart murmur	☐ Rheumatoid arthritis
☐ Asthma	☐ Heart rhythm disorder	☐ Severe headaches/migraines
☐ Autoimmune disease	☐ Hemophilia	☐ Severe or rapid weight loss
☐ Back problems	☐ Hepatitis, jaundice or liver disease	☐ Shingles
☐ Blood disease	☐ High blood pressure	☐ Sinus trouble
☐ Breathing problems/respiratory disease	☐ High cholesterol	☐ Stroke
☐ Cancer/chemotherapy/radiation	☐ Kidney problems	☐ Systemic lupus erythematosus
☐ Cardiovascular disease	☐ Low pain tolerance	☐ Thyroid problems
☐ Chronic pain	☐ Mitral valve prolapse	☐ TMJ disorder
☐ Congestive heart failure	☐ Neurological disorders	☐ Tumors or growths
☐ Damaged heart valves	☐ Osteoporosis/Paget's disease	☐ Ulcers
☐ Diabetes	☐ Other congenital heart defects	☐ Other

Please list any other medical condition not listed above:

MEDICATIONS

Please list all prescriptions and over the counter medications that you take:

ALLERGIES

☐ Acetaminophen/Tylenol	☐ Ibuprofen/Motrin/Advil
☐ Acrylic	☐ Iodine
☐ Amoxicillin	☐ Latex
☐ Aspirin	☐ Local anesthetic
☐ Codeine	☐ Metals
☐ Demerol	☐ Morphine
☐ Erythromycin	☐ Penicillin
☐ Fluoride	☐ Sulfa
☐ Food	☐ Tetracycline
☐ Hay fever/seasonal	☐ Other

Please elaborate on any reactions you have to indicated allergies

HEALTH HISTORY

Medical Physician's Name, Facility Name and Phone Number

Are you currently under a physician's care?

☐ Yes
☐ No

If yes, please explain:

Do you use tobacco?

☐ Yes
☐ No

Do you take a Pre-medication before appointments?

☐ Yes, if yes, why?
☐ No

Orthopedic/Heart Physician's Name, Facility Name and Phone Number

In the last 5 years, have you been hospitalized or had a major operation?

☐ Yes
☐ No

If yes, please explain:

I acknowledge I have answered all questions to the best of my ability.

Patient Signature:

Date: _____/_____/_____