MEDICAL HISTORY

Name_____ Nickname _____Age _____
Name of Physician & Specialty _____
Date of Most Recent Physical Exam ____/____/____ Purpose _____
How would you rate your health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO
1. Hospitalization for illness or injury _____	○	○
2. An allergic reaction to:		
Aspirin, ibuprofen, acetaminophen (Tylenol), codeine	○	○
Penicillin	○	○
Erythromycin	○	○
Tetracyline	○	○
Sulfa	○	○
Local anesthetic	○	○
Fluoride	○	○
Latex	○	○
Metals (nickel, silver, etc. _____)	○	○
Latex	○	○
Other	○	○
If yes, what symptoms do you experience? _____		
3. Heart problems _____	○	○
4. History of infective endocarditis _____	○	○
5. Artificial heart valve or repaired heart defect (PFO) _____	○	○
6. Pacemaker or implantable defibrillator _____	○	○
7. Artificial prosthesis (joints or heart valve) _____	○	○
8. Rheumatic or scarlet fever _____	○	○
9. High or low blood pressure _____	○	○
10. Stroke _____	○	○
11. Anemia or other blood disorder _____	○	○
12. Prolonged bleeding due to a slight cut (INR > 3.5) _____	○	○
13. Emphysema or sarcoidosis _____	○	○
14. Asthma _____	○	○
15. Tuberculosis _____	○	○
16. Breathing or sleep problems (e.g. snoring, sinus) _____	○	○
17. Kidney disease _____	○	○
18. Liver disease, jaundice_____	○	○
19. Thyroid, parathyroid disease or calcium deficiency _____	○	○
20. Hormone deficiency _____	○	○
21. High cholesterol _____	○	○

	YES	NO
22. Diabetes (If yes, what is your recent HbA1c level)_____	○	○
23. Stomach or duodenal ulcer _____	○	○
24. Digestive disorders (e.g. gastric reflux) _____	○	○
25. Osteoporosis / osteopenia _____	○	○
26. Are you, or have you, taken Bisphosphonates? _____	○	○
27. Arthritis _____	○	○
28. Glaucoma _____	○	○
29. Contact lenses _____	○	○
30. Head or neck injuries _____	○	○
31. Epilepsy, seizures or convulsions _____	○	○
32. Neurologic problems (e.g. ADD) _____	○	○
33. Viral infections, including cold sores _____	○	○
34. Any lumps or swelling in your mouth _____	○	○
35. Hives, skin rash, hay fever _____	○	○
36. STI / STD _____	○	○
37. Hepatitis (Type _____) _____	○	○
38. HIV / AIDS _____	○	○
39. Tumor or abnormal growth _____	○	○
40. Radiation therapy (Location _____) _____	○	○
41. Chemotherapy _____	○	○
42. Emotional problems _____	○	○
43. Antidepressant medications _____	○	○
44. Tobacco use _____	○	○
43. Alcohol use _____	○	○
44. Recreational drug use _____	○	○
ARE YOU:		
45. Aware of any change in your health? _____	○	○
46. Taking medications for weight management? _____	○	○
47. Experiencing frequent headaches? _____	○	○
48. Considered a 'touchy' person _____	○	○
49. FEMALE - Are you taking birth control medication? __	○	○
50. FEMALE – Are you pregnant? _____	○	○
51. MALE – Prostate disorders? _____	○	○

Please describe any medical treatments, upcoming surgeries, or ongoing procedures, such as Botox, collagen injections:

_____

Drug	Dosage	Drug	Dosage
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IF ANY CHANGE IN YOUR MEDICAL HISTORY OR THE MEDICATIONS YOU TAKE

_____ _____
Patient Signature Date

_____ _____
Doctor Signature Date