

## MEDICAL HISTORY

**CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT THE PRESENT TIME:**

Acid Reflux or G.E.R.D.  
Alzheimer's/Dementia/Memory Loss  
Anemia  
Angina  
anxiety or nervousness  
Artificial Joints (Hip/Knee/Shoulder)  
Arthritis (Osteo or Rheumatoid)  
Asthma  
Bisphosphonate use (medications used for bone preservation)  
Blood Transfusion  
Blood Thinners  
Cancer type: \_\_\_\_\_ Chemotherapy/Radiation  
Chronic Steroid Use  
Clotting Disorders  
Cold Sores or Canker Sores  
C.O.P.D.  
Crohn's Disease  
Depression  
Diabetes Type I or Type II  
DNR/Do Not Resuscitate  
Drug Dependency  
Eating Disorders  
Epilepsy or Seizures  
Eyes: Detached Retina/Glaucoma/Macular Degeneration  
Fibromyalgia  
Headaches / Migraines  
Hearing Loss / Hearing Aids

### MEDICATIONS (PRESCRIPTION / OTC / HERBAL)

### Heart Conditions:

Artificial Heart Valve  
AFIB  
Congestive Heart Failure  
Heart Attack  
Heart Defect  
Heart Murmur  
Heart Surgery  
High Blood Pressure  
Mitral Valve Prolapse  
Pacemaker  
Rheumatic Fever  
Stents or Shunts  
Hepatitis A, B, C, D  
HIV or AIDS  
HPV or Sexually Transmitted Disease  
Leukemia or Lymphoma  
Lupus  
Mental Health Disorder  
Multiple Sclerosis  
Neck or Spine problems and/or Surgery  
Nerve Disorder  
Osteoporosis OR Osteopenia  
Parkinson's Disease  
Pregnant (currently)  
Radiation Treatment  
Snoring or use of CPAP machine  
Sjogren's Syndrome  
Strong Gag Reflex  
Stroke  
Temporomandibular Joint Disorder (TMJ)  
Thyroid Problems OR Thyroid Surgery  
Tobacco Use; E-Cigs/Chew/Marijuana  
Ulcers  
Ulcerative Colitis  
**OTHER MEDICAL CONDITIONS?**

### ALLERGIES OR SENSITIVITIES TO MEDICATIONS:

Aspirin	Codeine	Iodine	LATEX	Sulfa
Acetaminophen	Epinephrine	Ibuprofen	Morphine	Tetracycline
Clindamycin	Erythromycin	Keflex	Penicillin	Valium

### **OTHER ALLERGIES:**

**PHYSICIAN:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_ **LAST PHYSICAL:** \_\_\_\_/\_\_\_\_/\_\_\_\_

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE A CHANGE IN MY HEATH HISTORY OR MEDICINE, I WILL INFORM THE DOCTOR OR STAFF AT THE NEXT APPOINTMENT WITHOUT FAIL.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE