Medical History

Last Name: _____ First Name: _____ Birthdate: _____
Address: _____ City/State/Zip: _____
E-mail: _____ Phone _____ Sex: _____
Physician Name & Specialty: _____ Number: _____
Most recent physical examination _____ Purpose: _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you ever had:

	Y	N	DK
Hospitalization for illness or injury_____			
Heart problems, or cardiac stent within 6 months_____			
History of infective endocarditis _____			
Artificial heart valve, repaired heart defect (PFO)_____			
Pacemaker or implantable defibrillator _____			
Orthopedic/Soft Tissue Implant (joint replacement, etc.)			
Heart Murmur, rheumatic or scarlet fever _____			
High or Low Blood Pressure_____			
A stroke (taking blood thinners)_____			
Anemia or other blood disorder_____			
Prolonged bleeding due to a slight cut (or INR>3.5)___			
Pneumonia, emphysema, shortness of breath, sarcoldosis_			
Chronic ear infections, tuberculosis, measles, chicken pox_			
Sleeping Problems (snoring, insomnia, sleep apnea, etc.)_			
Kidney disease_____			
Liver disease or jaundice_____			
Vertigo ("the room is spinning")_____			
Thyroid, parathyroid disease, or calcium deficiency__			
Hormone deficiency or imbalance (poly cystic ovarian syndrome)___			
High cholesterol or taking statin drugs_____			
Diabetes (HbA1c=_____) _____			
Stomach or duodental ulcer_____			

	Y	N	DK
Digestive or eating disorder (bulimia, gastric reflux, etc.)_____			
Arthritis or gout_____			
Autoimmune disease (rheumatoid arthritis, lupus, scleroderma) _____			
Glaucoma _____			
Contact lenses _____			
Head or neck injuries_____			
Epilepsy, convulsions (seizures) _____			
Neurologic disorders (Alzheimer's disease, dementia, etc) __			
Viral infections and cold sores _____			
Any lumps or swelling in the mouth _____			
Hives, skin rash, hay fever _____			
STI/STD/HPV _____			
Hepatitis (type____) _____			
HIV/AIDS _____			
Tumor, abnoramal growth _____			
Radiation therapy _____			
Chemotherapy, immunosuppressive medication			
Emotional difficulties _____			
Psychiatric treatment or antidepressant medication ____			
Concentration problems or ADD/ADHD _____			
Alcohol/recreational drug use _____			
Osteoporosis/Osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates)			

Are You:

	Y	N	DK
Presently being treated for any illness _____			
Change in your health in the last 24 hours (fever, diarrhea...)			
Taking medication for weight managment _____			
Taking dietary supplements, vitamins, and/or probiotics			
Often exhausted or fatigued_____			
Experiencing frequent headaches or chronic pain_____			

	Y	N	DK
A smoker, smoked previously or other (vaping, cannabis...)___			
Considered a touchy/sensitive person_____			
Ofter unhappy or depressed_____			
Taking birth control pills_____			
Currently pregnant_____			
Diagnosed with prostate disorder_____			

Allergic or a reaction to the following:

	Y	N	DK
Aspirin _____			
Ibuprofen _____			
Local Anesthetic ___			
Metals (Nickel, gold)			
Acetaminophen____			
Codeine _____			
Fluoride _____			
Latex _____			
Penicillin _____			
Erythromycin _____			

	Y	N	DK
Chlorhexidine(CHX)			
Nuts _____			
Tetracyline_____			
Sulfa _____			
Iodine_____			
Fruit_____			
Milk_____			
Red Dye_____			
Other_____			

Patient Signature DATE:

Doctor Signature Date:

List all medications that you are now taking:

_____
_____
_____
_____