CONFIDENTIAL MEDICAL HISTORY

Patient Name _____

Do you have a physician? ☐ No ☐ Yes If yes, please list name(s) _____

Have you had a medical exam in the past two years? ☐ No ☐ Yes For _____

Have you ever been hospitalized for illness or surgery? ☐ No ☐ Yes For _____

Do you require antibiotic premedication for dental visits? ☐ No ☐ Yes For _____

Have you ever had an allergic reaction or bad reaction to:

☐ Aspirin or ibuprofen
☐ Codeine
☐ Penicillin
☐ Tetracycline
☐ Sulfa drugs
☐ Metals
☐ Latex
☐ Other_____

Are you sensitive to local anesthetics? ☐ No ☐ Yes Type of reaction _____

Please list all medications and health supplements you are taking. ***If you have a list of medications provided by your doctor's office, we can make a photocopy of the list instead.***

Do you have or have you ever had:

☐ Heart problems or cardiac stents placed within the past six months _____
☐ History of infective endocarditis _____
☐ Artificial heart valve or repaired heart defect _____
☐ Pacemaker or implantable defibrillator _____
☐ Joint replacement or other type of implant _____
☐ High or low blood pressure _____
☐ Stroke (taking blood thinners) _____
☐ Anemia or other blood disorder _____
☐ Prolonged bleeding due to a slight cut (INR>3.5) _____
☐ Emphysema, shortness of breath or sarcoidosis
☐ Tuberculosis, measles, shingles or chicken pox
☐ Asthma or other breathing problem (COPD, etc.)
☐ Sleep problems (apnea, snoring, insomnia, RLS)
☐ Kidney disease _____
☐ Liver disease, hepatitis or jaundice _____
☐ Thyroid or parathyroid disease _____
☐ Hormone deficiency or imbalance _____
☐ High cholesterol or taking statin drugs
☐ Diabetes Most recent HbA1c? _____
☐ Stomach or digestive disorder (ulcer, celiac disease, gastric reflux, bulimia) _____
☐ Osteoporosis, osteopenia or taken bisphosphonate drugs
☐ Arthritis _____
☐ Autoimmune disorder (Rheumatoid arthritis, lupus, scleroderma, multiple sclerosis) _____
☐ Glaucoma _____
☐ Hearing loss or hearing aids
☐ Head or neck injury _____
☐ Epilepsy, convulsions or seizures _____
☐ Neurologic disorder (Alzheimers, dementia, ADHD, autism)
☐ Viral infection or cold sores _____
☐ Lumps or swelling in the mouth _____
☐ Hay fever, sinusitis or seasonal allergies _____
☐ Hives, skin rash, seasonal allergies _____
☐ STI/STD/HPV _____
☐ HIV/AIDS _____
☐ Tumor or abnormal growth _____
☐ Radiation therapy or chemotherapy _____
☐ Immune suppressant medication _____
☐ Gender transition _____
☐ Emotional difficulties _____
☐ Psychiatric therapy or antidepressant medication
☐ Medical or recreational cannabis use _____
☐ Alcohol or recreational drug use _____
☐ Substance abuse disorder or treatment _____

Are you:

☐ Presently being treated for any other condition not indicated above _____
☐ Aware of a change in your health in the last 24 hours
☐ Taking medication for weight management _____
☐ Taking dietary supplements _____
☐ Often exhausted or fatigued _____
☐ Experiencing frequent headaches or chronic pain
☐ Past/present smoker or tobacco/vape/e-cig user
☐ Considered a sensitive/touchy person
☐ Often unhappy or depressed
☐ Taking birth control pills _____
☐ Currently pregnant _____
☐ Having a prostate disorder _____