Medical History

First Name: _____ Last Name: _____ Birthdate: _____

Are you currently under the care of a Physcian? _____ Name of Medical Doctor: _____

Date of last physical exam? _____ Do you have dental pain? ☐ Yes ☐ No Type: _____

Hospitalizations or Surgeries (Date & Reason): _____

Ever Taken: Phen-Fen, Redux, Fosamax, Boniva, Actonel or Medications w/Bisphosphonates? ☐

Women: Pregnant? or Trying? ☐ Due Date: _____ Nursing? ☐ Birth Control? ☐ Type: _____

EMERGENCY CONTACT: Name: _____ Relation: _____ Phone: _____

Current Vitamins, Supplements, & Medications (Prescribed, OTC, or Homeopathic):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Allergy or Previous Allergic Reaction:

☐ Aspirin ☐ Latex (Rubber) ☐ Penicillin ☐ Other Antibiotic (List): _____

☐ Codeine ☐ Local Anesthetic ☐ Seasonal Allergies

☐ Ibuprofen ☐ Metals ☐ Sulfa Drugs ☐ Other Allergy (List): _____

☐ Iodine ☐ Nut Allergy

Foreign Travel in the Last 30 Days? ☐ Yes Location & Dates: _____

Current Medical Condition(s) or History of the Following Medical Condition(s):

ENMT:

☐ Cataracts
☐ Cold Sores (Herpes)
☐ Excessive Thirst
☐ Glaucoma
☐ Hearing Loss (Deafness)
☐ Jaw Joint Pain
☐ Tonsililitis
☐ Sinus Trouble
☐ Other ENMT Condition: _____

Habitual:

☐ Tobacco Use (Type):
- ☐ Cigarettes
- ☐ Vape / Hookah
- ☐ Cigars
- ☐ Tobacco Pipe
- ☐ Smokeless (Chew)

How Much, How Often: _____

☐ Controlled Substance (Type): _____

How Much, How Often: _____

Cardiovascular:

☐ Angina (Chest Pain)
☐ Artificial Heart Valve
☐ Congenital Heart Disease
☐ Congestive Heart Failure
☐ Heart Attack
☐ Heart Murmur
☐ Heart Pacemaker
☐ High Blood Pressure
☐ High Cholesterol
☐ Irregular Heartbeat
☐ Swelling of Limbs
☐ Other Cardio. Condition: _____

Musculoskeletal:

☐ Arthritis (List Diagnosis): _____

☐ Artificial Joints (Location): _____

☐ Cortisone Injections
☐ Convulsions
☐ Epilepsy/Seizures
☐ Gout
☐ Osteoporosis
☐ Rheumatism

Neurological:

☐ Alzheimer's Disease
☐ Autism
☐ Depression
☐ Dizziness
☐ Drug Addiction
☐ Fainting
☐ Frequent Headaches
☐ Mental Disability (List): _____

☐ Migraines
☐ Psychiatric Treatment
☐ Stroke
☐ Other Neuro. Condition: _____

Respiratory:

☐ Anaphylaxis
☐ Asthma
☐ COPD
☐ Emphysema
☐ Frequent Cough
☐ Shortness of Breath
☐ Sleep Apnea
☐ Wheezing
☐ Other Respir. Condition: _____

Systemic:

☐ AIDS/HIV
☐ Acid Reflux/GERD
☐ Anemia
☐ Cancer (List Diagnosis): _____
- ☐ Chemotherapy
- ☐ Radiation Therapy

☐ Celiac Disease
☐ Diabetes
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Kidney Failure
☐ Liver Failure
☐ Low Blood Sugar
☐ Lung Failure
☐ Stomach/Intestinal Issues: _____

☐ Thyroid Issues
☐ Tumors (List Diagnosis): _____

☐ Ulcers (List Diagnosis): _____

☐ Other Medical Condition: _____