Medical History

Do you have any of the following Check, if applicable?

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Abnormal Bleeding *
○ Yes ○ No

AIDS/HIV Infection *
○ Yes ○ No

Alcohol/Drug Abuse *
○ Yes ○ No

Alzheimers *
○ Yes ○ No

Anaphylaxis *
○ Yes ○ No

Anemia *
○ Yes ○ No

Angina *
○ Yes ○ No

Ankles Swell *
○ Yes ○ No

Anorexia *
○ Yes ○ No

Arteriosclerosis *
○ Yes ○ No

Arthritis/Gout *
○ Yes ○ No

Artificial Heart Valve *
○ Yes ○ No

Artificial Joint(s) *
○ Yes ○ No

Asthma *
○ Yes ○ No

Autoimmune Disease *
○ Yes ○ No

Heart Disease *
○ Yes ○ No

Heart Murmur *
○ Yes ○ No

Hemophillia *
○ Yes ○ No

Hepatitis A, B, or C *
○ Yes ○ No

Herpes *
○ Yes ○ No

High Blood Pressure *
○ Yes ○ No

Hives or Rash *
○ Yes ○ No

Hypoglycemia *
○ Yes ○ No

Irregular Heartbeat *
○ Yes ○ No

Jaundice *
○ Yes ○ No

Kidney *
○ Yes ○ No

Leukemia *
○ Yes ○ No

Liver Disease *
○ Yes ○ No

Low Blood Pressure *
○ Yes ○ No

Lung Disease *
○ Yes ○ No

Bladder Trouble *

○ Yes ○ No

Blood Clotting Problems *

○ Yes ○ No

Blood Transfusion *

○ Yes ○ No

Breathing Problems *

○ Yes ○ No

Bronchitis *

○ Yes ○ No

Bruise Easily *

○ Yes ○ No

Bulimia *

○ Yes ○ No

Cancer / Tumor or Growth *

○ Yes ○ No

Cardiac Pacemaker *

○ Yes ○ No

Cardiovascular Disease *

○ Yes ○ No

Chemotherapy *

○ Yes ○ No

Chest Pain Upon Exertion *

○ Yes ○ No

Cold Sores *

○ Yes ○ No

Color Blindness *

○ Yes ○ No

Congenital Heart Disorder *

○ Yes ○ No

Congestive Heart Failure *

○ Yes ○ No

Contact Lenses *

○ Yes ○ No

Convulsions *

○ Yes ○ No

Cortisone Medicine *

○ Yes ○ No

Damaged Heart Valve *

○ Yes ○ No

Lupus *

○ Yes ○ No

Mental Health Problems *

○ Yes ○ No

Mitral Valve Prolapse *

○ Yes ○ No

No Change Since Last Recorded *

○ Yes ○ No

No Known Concerns or Issues *

○ Yes ○ No

Pacemaker *

○ Yes ○ No

Pain in Jaw Joints *

○ Yes ○ No

Parathyroid Disease *

○ Yes ○ No

Persistent Diarrhea *

○ Yes ○ No

Premedicate *

○ Yes ○ No

Psychiatric Care *

○ Yes ○ No

Radiation Treatment *

○ Yes ○ No

Recent Weight loss *

○ Yes ○ No

Renal Dialysis *

○ Yes ○ No

Rheumatic Fever *

○ Yes ○ No

Rheumatic Heart Disease *

○ Yes ○ No

Rheumatoid Arthritis *

○ Yes ○ No

Scarlet Fever *

○ Yes ○ No

Seizures *

○ Yes ○ No

Sexually Transmitted Disease *

○ Yes ○ No

Diabetes *
Yes No

Drug Addiction *
Yes No

Emphysema *
Yes No

Environmental Allergies *
Yes No

Epilepsy *
Yes No

Excessive Bleeding *
Yes No

Excessive Thirst *
Yes No

Fainting Spells/Dizziness *
Yes No

Fever Blisters *
Yes No

Frequent Cough *
Yes No

Frequent Diarrhea *
Yes No

Frequent Headaches *
Yes No

Frequently Dry Mouth / Sjogren *
Yes No

Gag Reflex *
Yes No

Gall Bladder Trouble *
Yes No

Genital Herpes *
Yes No

Glaucoma *
Yes No

Hay Fever *
Yes No

Heart Attack/Failure *
Yes No

Shingles *
Yes No

Shortness of Breath *
Yes No

Sickle Cell Disease *
Yes No

Sinus Trouble *
Yes No

Skin Rash *
Yes No

Spina Bifida *
Yes No

Stomach Ulcers *
Yes No

Stomach/Intestine Disease *
Yes No

Stroke *
Yes No

Swelling of Limbs *
Yes No

Thyroid Problems *
Yes No

Tonsilitis *
Yes No

Tuberculosis *
Yes No

Tumors or Growth *
Yes No

Ulcers *
Yes No

Unusual Weight Loss *
Yes No

Urinate Frequently *
Yes No

Venereal Disease *
Yes No

Yellow Jaundice *
Yes No

Current edications and supplements

Do you have any of the following Allergic to?

Do you have any of the following Allergic to?

Aspirin *
○ Yes ○ No

Barbiturates / Sleeping Pills *
○ Yes ○ No

Codeine *
○ Yes ○ No

Erythromycin *
○ Yes ○ No

Iodine *
○ Yes ○ No

Latex Rubber *
○ Yes ○ No

Local Anesthetics *
○ Yes ○ No

Metals *
○ Yes ○ No

No Epinephrine *
○ Yes ○ No

No Known Allergies *
○ Yes ○ No

Other *
○ Yes ○ No

Other Narcotics *
○ Yes ○ No

Penicillin *
○ Yes ○ No

Prior Hepatitis *
○ Yes ○ No

Seasonal Allergies *
○ Yes ○ No

Sulfa Drugs *
○ Yes ○ No

Add unlisted Allergic to here (one item per entry)

Enter the item not listed here

Do you have any of the following Other?

Do you have any of the following Other?

Add unlisted Other here (one item per entry)

Enter the item not listed here

Additional Questions

Additional Questions

Date of last exam

MM/dd/yyyy

Have you had any serious illness, operation, or hospitalization in the past 5 years? *
○ Yes ○ No

Are you on a special diet? *
○ Yes ○ No

Have you had any head or neck injuries? *

Yes No

Do you experience any tooth sensitivity? *

Yes No

Do you grind your teeth? *

Yes No

Do you smoke or chew tobacco? *

Yes No

Patient's First Name *

Patient's Last Name *

Sign Here

Signature *

Date *

10/08/2024