Medical History

Patient Name: _____Date of Birth_____

Name of Physician/Last date of exam_____

*List all Medications, supplements, and or vitamins taken_____

_____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair

Do you have or have you ever had:

YES NO

1. *Hospitalization for illness or injury? ☐ ☐
2. *An allergic or bad reaction to any of the following:
   - Aspirin, ibuprofen acetaminophen, codeine
   - Penicillin
   - Erythromycin
   - Tetracycline
   - Sulfa
   - Local anesthetic
   - Fluoride
   - Chlorhexidine (CHX)
   - Metals (nickel, gold, silver, _____)
   - Latex
   - Nuts_____
   - Fruit_____
   - Milk_____
   - Red dye_____
   - Other_____
3. *Osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates)_____ ☐ ☐
4. *A smoker, smoked previously or other (smokeless tobacco, vaping, e-cigarettes, and cannabis)_____ ☐ ☐
5. *Orthopedic or soft tissue implant(e.g. joint replacement, breast implant)_____ ☐ ☐
6. *Currently pregnant_____ ☐ ☐
7. Heart problems, or cardiac stent within the last six months_____ ☐ ☐
8. History of infective endocarditis_____ ☐ ☐
9. Artificial heart valve, repaired heart defect (PFO)___ ☐ ☐
10. Pacemaker or implantable defibrillator_____ ☐ ☐
11. Heart murmur, rheumatic or scarlet fever_____ ☐ ☐
12. High or low blood pressure_____ ☐ ☐
13. A stroke (taking blood thinners)_____ ☐ ☐
14. Anemia or other blood disorder_____ ☐ ☐
15. Prolonged bleeding due to a slight cut(or INR>3.5)__ ☐ ☐
16. Pneumonia, emphysema, shortness of breath, sarcoidosis_____ ☐ ☐
17. Chronic ear infections, tuberculosis, measles, chicken pox_____ ☐ ☐
18. Breathing problems (e.g. asthma, stuffy nose, sinus congestion)_____ ☐ ☐
19. Sleeping problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting)_____ ☐ ☐
20. Kidney disease_____ ☐ ☐
21. Liver disease or jaundice_____ ☐ ☐
22. Vertigo (e.g. “the room is spinning”)_____ ☐ ☐
23. Thyroid, parathyroid disease or calcium deficiency__ ☐ ☐
24. Hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome)_____ ☐ ☐
25. High cholesterol or taking statin drugs_____ ☐ ☐
26. Diabetes (HbA1c=_____)_____ ☐ ☐
27. Stomach or duodenal ulcer_____ ☐ ☐
28. Digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia)_____ ☐ ☐
29. Arthritis or gout_____ ☐ ☐
30. Autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma)_____ ☐ ☐
31. Glaucoma_____ ☐ ☐
32. Contact lenses_____ ☐ ☐
33. Head or neck injuries_____ ☐ ☐
34. Epilepsy, convulsions (seizures)_____ ☐ ☐
35. Neurologic disorders (ADD, ADHD, prion disease)____ ☐ ☐
36. Viral infections and cold sores_____ ☐ ☐
37. Any lumps or swelling in the mouth_____ ☐ ☐
38. Hives, skin rash, hay fever_____ ☐ ☐
39. STI/STD/HPV_____ ☐ ☐
40. Hepatitis (Type_____ ☐ ☐
41. HIV/AIDS_____ ☐ ☐
42. Tumor, abnormal growth_____ ☐ ☐
43. Radiation therapy_____ ☐ ☐
44. Chemotherapy, immunosuppressive medication_____ ☐ ☐
45. Emotional difficulties_____ ☐ ☐
46. Psychiatric treatment or antidepressant medication__ ☐ ☐
47. Concentration problems or ADD/ADHD diagnosis____ ☐ ☐
48. Alcohol/recreational drug use_____ ☐ ☐
49. Presently being treated for any other illness_____ ☐ ☐
50. Aware of a change in your health in the last 24 hours (e.g. fever, chill, new cough, or diarrhea)_____ ☐ ☐
51. Often exhausted or fatigued_____ ☐ ☐
52. Experiencing frequent headaches or chronic pain___ ☐ ☐
53. Diagnosed with a prostate disorder_____ ☐ ☐

Patient’s Signature _____Doctor’s Signature_____