Health History Form

REASON FOR VISIT: Checkup _____ Cleaning _____ Toothache _____ Other _____

GENERAL MEDICAL HISTORY

1. Are you under a doctor's care at this time? _____ If yes, please specify _____

Dr. Name _____ Phone number (_____) _____

2. List drug allergies or reactions to any medicines _____

3. List current medications _____

4. (Women) Are you pregnant now? _____ If yes, how many weeks? _____ Are you nursing? _____

DETAILED MEDICAL HISTORY (Please check "YES" or "NO" for all)

GASTROINTESTINAL / LIVER / BLOOD / METABOLIC

Do you have any gastrointestinal, liver, blood, or metabolic conditions?	☐ YES	☐ NO
Hepatic (liver) disease	☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO
Renal (kidney) disease	☐ YES	☐ NO
Unusual bleeding	☐ YES	☐ NO
Sickle cell anemia / trait	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
If yes, which type?	☐ **Type I**	☐ **Type II**
Gastrointestinal (GI) disease or condition	☐ YES	☐ NO
Thyroid disease	☐ YES	☐ NO

PULMONARY

Do you have a lung or breathing condition?	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Chronic obstructive pulmonary disease (COPD)	☐ YES	☐ NO

NERVOUS SYSTEM

Do you have any nervous system conditions?	☐ YES	☐ NO
Seizures	☐ YES	☐ NO
Stroke / TIA	☐ YES	☐ NO
Syncope (fainting)	☐ YES	☐ NO

CARDIOVASCULAR / HEMATOLOGY

Do you have any heart, circulatory or blood pressure conditions?	☐ YES	☐ NO
Heart Attack (MI)	☐ YES	☐ NO
Congestive heart failure	☐ YES	☐ NO
Angina (chest pain)	☐ YES	☐ NO
Heart surgery / stent / valve placement	☐ YES	☐ NO
Hypertension (high blood pressure)	☐ YES	☐ NO
If yes, what is your usual BP? _____		
Arrhythmia	☐ YES	☐ NO
Pacemaker / ICD	☐ YES	☐ NO

INFECTIOUS DISEASES

Do you have any infectious diseases?	☐ YES	☐ NO
Tuberculosis (TB)	☐ YES	☐ NO
HIV / AIDS	☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO

ORTHOPEDIC / MUSCULOSKELETAL

Do you have any orthopedic or musculoskeletal diseases?	☐ YES	☐ NO
Bone problems or diseases (i.e. osteoporosis)	☐ YES	☐ NO
Artificial joints	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Muscle problems or diseases	☐ YES	☐ NO
If yes, which: _____		
Jaw or jaw joint problems (TMD)	☐ YES	☐ NO

OTHER

			If yes, which:
Cancer	☐ YES	☐ NO	_____
Emotional/Psychiatric disorders	☐ YES	☐ NO	_____
Frequent sinus infections	☐ YES	☐ NO	
Sleep apnea	☐ YES	☐ NO	
Other medical conditions	☐ YES	☐ NO	_____

_____

Alcoholism	☐ YES	☐ NO
Drug addiction	☐ YES	☐ NO
Cigarette smoker	☐ YES	☐ NO
Tobacco	☐ YES	☐ NO
E-cigarettes	☐ YES	☐ NO