MEDICAL HISTORY

Do you have any of the following allergies?

Acrylic
☐ Yes ☐ No

Anesthetics
☐ Yes ☐ No

Any Dyes
☐ Yes ☐ No

Aspirin
☐ Yes ☐ No

Codeine
☐ Yes ☐ No

Food Allergies
☐ Yes ☐ No

Iodine
☐ Yes ☐ No

Latex
☐ Yes ☐ No

Nickel
☐ Yes ☐ No

Penicillin/Amoxicillin
☐ Yes ☐ No

Seasonal Allergies
☐ Yes ☐ No

Sulfa Drugs
☐ Yes ☐ No

Tylenol
☐ Yes ☐ No

Valium
☐ Yes ☐ No

☐ I have disclosed all my allergies.

PLEASE LIST ANY ALLERGIES NOT LISTED ABOVE

Do you have, or have you ever had any of the following health conditions?

Celiac Disease
☐ Yes ☐ No

Crohn's/Ulcerative Colitis
☐ Yes ☐ No

Fibromyalgia
☐ Yes ☐ No

HIV/AIDS
☐ Yes ☐ No

Lupus
☐ Yes ☐ No

Rheumatoid Arthritis (RA)
☐ Yes ☐ No

Scleroderma
☐ Yes ☐ No

Sjogren's Syndrome
☐ Yes ☐ No

Cancer Diagnosis/Tumors
☐ Yes ☐ No

Chemotherapy
☐ Yes ☐ No

Anorexia/Bulimia
☐ Yes ☐ No

Chronic Nausea/Vomiting
☐ Yes ☐ No

Gastric Reflux (GERD)
☐ Yes ☐ No

Heartburn/Indigestion
☐ Yes ☐ No

Ulcers
☐ Yes ☐ No

Heart Attack
☐ Yes ☐ No

Heart Surgery
☐ Yes ☐ No

Heart Valve Replacement
☐ Yes ☐ No

High Blood Pressure
☐ Yes ☐ No

History of Endocarditis
☐ Yes ☐ No

Joint Replacement
☐ Yes ☐ No

Multiple Sclerosis (MS)
☐ Yes ☐ No

Neuritis/Neuralgia
☐ Yes ☐ No

Osteoarthritis
☐ Yes ☐ No

Osteoporosis/Osteopenia
☐ Yes ☐ No

Parkinson's Disease
☐ Yes ☐ No

ADD/ADHD
☐ Yes ☐ No

Alzheimer's/Dementia/Memory Loss
☐ Yes ☐ No

Anxiety/Panic Attack
☐ Yes ☐ No

Concussion/Cognitive Impairment
☐ Yes ☐ No

Radiation Therapy
☐ Yes ☐ No

History of Stroke
☐ Yes ☐ No

Depression
☐ Yes ☐ No

Recent Dramatic Weight Loss
☐ Yes ☐ No

Swelling of Hands and/or Feet (Edema)
☐ Yes ☐ No

Developmental or Intellectual Disabilities
☐ Yes ☐ No

Alcoholism
☐ Yes ☐ No

Abnormal Heartbeat (Arrythmia)
☐ Yes ☐ No

Other Psychiatric Disorder
☐ Yes ☐ No

Chewing Tobacco/Snuff
☐ Yes ☐ No

Bruise Easily
☐ Yes ☐ No

Breastfeeding
☐ Yes ☐ No

Cigarettes/Cigars/Pipe Smoking
☐ Yes ☐ No

Blood Disorder
☐ Yes ☐ No

Currently or Potentially Pregnant
☐ Yes ☐ No

Electronic Cigarettes
☐ Yes ☐ No

Chest Pain (Angina)
☐ Yes ☐ No

Asthma
☐ Yes ☐ No

History of Drug Addiction
☐ Yes ☐ No

Congenital Heart Defect/Aortic Stenosis
☐ Yes ☐ No

COPD (Emphysema/Chronic Bronchitis)
☐ Yes ☐ No

Diabetes
☒ Yes ☐ No

Fainting Spells
☐ Yes ☐ No

Cystic Fibrosis
☐ Yes ☐ No

Hepatitis/Liver Disease
☐ Yes ☐ No

Blood Thinners
☐ Yes ☐ No

Tuberculosis
☐ Yes ☐ No

Hypoglycemia
☐ Yes ☐ No

Pacemaker
☐ Yes ☐ No

Surgeries
☐ Yes ☐ No

Increased Thirst
☐ Yes ☐ No

Chronic Back Pain
☐ Yes ☐ No

Migraines/Chronic Headaches
☐ Yes ☐ No

Kidney Disease
☐ Yes ☐ No

ALS Lou Gehrig's Disease
☐ Yes ☐ No

Other
☐ Yes ☐ No

Thyroid Disorder/Hashimoto's
☐ Yes ☐ No

Epilepsy/Seizures
☐ Yes ☐ No

Sleep Apnea
☐ Yes ☐ No

Are you currently taking or have you ever taken Bisphosphonates?
☐ Yes ☐ No

PLEASE LIST ANY OTHER CONDITIONS NOT LISTED ABOVE

PLEASE LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING IN THE SPACES BELOW

EXISTING PATIENTS Check the box next to any medication no longer being taken.

1. ☐ _____
2. ☐ _____
3. ☐ _____
4. ☐ _____
5. ☐ _____
6. ☐ _____
7. ☐ _____
8. ☐ _____
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12. ☐ _____
13. ☐ _____
14. ☐ _____
15. ☐ _____
16. ☐ _____
17. ☐ _____
18. ☐ _____
19. ☐ _____
20. ☐ _____

Patient's First Name _____

Patient's Last Name _____

Patient's Date of Birth _____

Name of Parent or Guardian (if patient is a minor)

_____

Patient/Guardian Signature

Date

_____