Health History Form

Patient Information

Patient First Name | MI | Patient Last Name | Patient Date of Birth

SUMMARY

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

GENERAL HEALTH INFORMATION

Physician | Physician phone number | Date of last physical exam

Are you presently being treated for any injury or illness? Y N

Have you ever been hospitalized for an injury or illness? Y N

Are you pregnant or planning to become pregnant? Y N

Are you currently breastfeeding? Y N

Are you required to pre-med with antibiotics before dental treatment? Y N

Do you use or have you ever used tobacco? Y N

Do you use alcohol? Y N

Have you ever had an allergic reaction? Y N

MEDICAL CONDITIONS

Do you have a history or are currently being treated for any Digestive conditions? Y N

Do you have a history or are currently being treated for any Lung or Breathing conditions? Y N

Do you have a history or are currently being treated for any Heart or Circulatory conditions? Y N

Do you have a history or are currently being treated for any Autoimmune conditions? Y N

Do you have a history or are currently being treated for any Neurological conditions? Y N

Head or neck injuries? Y N

Artificial Joint Y N

High cholesterol? Y N

History of cancer? Y N

Tumor or abnormal growth? Y N

Radiation Therapy? Y N

Chemotherapy? Y N

HIV / AIDS? Y N

Osteoporosis / osteopenia? Y N

Type I or Type II diabetes? Y N

Anemia? Y N

Kidney disease? Y N

Liver disease? Y N

Thyroid disease? Y N

Tuberculosis / measles / chicken pox? Y N

Any other medical conditions we should know of?

MEDICATIONS

Are you taking any pain medications? Y N

Are you taking any Antidepressants or Anxiety medications? Y N

Are you taking any Diabetes, Cholesterol, or Blood Pressure medications? Y N

Are you taking any Allergy or Asthma medications? Y N

Are you taking any Antibiotics? Y N

Are you currently taking any other medications or dietary supplements? Y N

Patient's Signature

Date

Doctor's Signature

Date