ASA:_____

Medical History

Updated: Jan 2019

Patient's Name:_____ **Birthdate (MM/DD/YY)** :_____

FamilyDoctor: _____ Pharmacy:_____

Dr's Phone #_____ Pharmacy Phone #:_____

Pharmacy Fax: _____

Do you have any of the following conditions?		UPDATED
( ) Smoker, previously smoked, smokeless tobacco	( ) Liver Disease	_____
( ) High Blood Pressure	( ) Hepatitis A B C Active/ Carrier	_____
( ) Heart Disease- Atrial fib, Vent fib, CHF,	( ) Alcoholism	_____
( ) Artificial Heart Valves, Unrepaired Heart defect Hx Endocarditis, Donor Heart Recipient	( ) Mental or Nervous Disorder, ADHD Autism Spectrum	_____ _____
( ) Angina?	( ) Depression, Anxiety	_____
( ) Heart surgery? What? When?	( ) Dental/Needle Phobia	_____
( ) Heart Attack? When?	( ) Epilepsy/Convulsions	_____
( ) Stroke When?	( ) Osteoporosis	_____
( ) Pacemaker Placed when?	( ) Thyroid Problem Hyper, Hypo	_____
( ) High Cholesterol	( ) Arthritis- osteo/rheumatoid	_____
( ) Excessive bleeding/Blood Thinners	( ) Joint Replacement-Hip, Knee,	_____
( ) Blood Disease-What?	Date of sx?	_____
( ) T.B. When?	( ) Autoimmune Disorders	_____
( ) Emphysema, C.O.P.D	( )Fibromyalgia ( )Crohn's ( )MS	_____
( ) Asthma- Mild, Mod, Severe	( ) Cancer-Type? Tx?	_____
( ) Hay Fever-Mild, Mod, Severe	( ) Venereal Disease/HIV/AIDS	_____
( ) Sleep Apnea mild, mod, severe	( ) Use recreational drugs routinely	_____
( ) Acid Reflux Disease	( ) Use Medical Marijuana	_____
( ) Intestinal Problems/Stomach Ulcers/Celiac	( ) Glaucoma	_____
( ) Diabetes ( ) Type I, ( ) Type II	( ) Gout	_____
( ) Stable,( ) Unstable		_____
( ) Kidney Disease		_____
Have you ever had Unusual Reactions to any of the Following? (please note reaction)		_____
( ) Latex, Bandaids	( ) Penicillin, Amoxicillin	_____
( ) Anesthetics: GA, Local	( ) Clindamycin	_____
( ) Chlorhexidine	( ) Sulfa	
( ) Codeine, Morphine	( ) Tetracycline, doxycycline	
( ) Ibuprofen, Toradol, NSAIDs	( ) Erythromycin	
( ) Aspirin	( ) Metals What?	
( ) Tylenol	( ) Nuts	_____
( ) Mint/Fluoride	( ) Milk	
( ) Other _____		

Is there anything else regarding your health that we have not discussed that you feel would be important for us to know before we begin treatment?_____

Patient's Signature:_____ Date:_____