ASA:_____

Medical History

Updated: Nov 2019

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

Family Doctor: _____ Pharmacy: _____

Doctor Phone/City: _____ Pharmacy Phone: _____

Pharmacy Fax: _____

PRE-MED REQUIRED: _____

UPDATED

Do you have any of the following conditions?

( ) Smoker (Circle) Frequency: _____ Cigarettes, Cigars, Vaping, Previous Use, Chew Tobacco	( ) Cancer Type:_____ Tx: Radiation, Chemo, Surgery	_____
( ) High blood pressure	( ) Hepatitis A B C Active/ Carrier	_____
( ) Heart disease- Atrial fib, Vent fib, CHF,	( ) Liver disease	_____
( ) Artificial heart valves, Unrepaired heart defect Hx Endocarditis, Donor Heart Recipient	( ) Mental or Nervous disorder, ADHD Autism Spectrum	_____
( ) Angina? Nitro spray Y / N	( ) Depression ( ) Anxiety	_____
( ) Heart surgery? Date:	( ) Dental/Needle Phobia/Gagger	_____
( ) Heart attack? Date:	( ) Epilepsy/Convulsions	_____
( ) Stroke? Date:	( ) Osteoporosis ( ) Bisphosphonates	_____
( ) Pacemaker Date placed:	( ) Thyroid problem Hyper, Hypo	_____
( ) High cholesterol	( ) Arthritis- osteo/rheumatoid	_____
( ) Excessive bleeding/blood thinners	( ) Joint replacement – Hip, Knee, Other	_____
( ) Blood disease-What?	Date of Surgery:	_____
( ) T.B. When?	( ) Autoimmune disorders	_____
( ) Emphysema, C.O.P.D	( ) Fibromyalgia ( ) Crohn's ( ) MS	_____
( ) Asthma – Mild, Mod, Severe	( ) Other:	_____
( ) Hay fever – Mild, Mod, Severe	( ) Venereal disease/HIV/AIDS	_____
( ) Sleep apnea Dx: Tx:	( ) Recreational drug use	_____
( ) Acid reflux disease	( ) Marijuana use	_____
( ) Intestinal problems/Stomach ulcers/Celiac	( ) Glaucoma	_____
( ) Diabetes ( ) Type I ( ) Type II	( ) Gout	_____
HgA1c: Date:	( ) Alcoholism	_____
( ) 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 (CHX)	( ) Sulfa	
( ) Codeine, Morphine	( ) Tetracycline, Doxycycline	
( ) Ibuprofen, Toradol, NSAIDs	( ) Erythromycin	
( ) Aspirin	( ) Metals (nickel, gold, silver, other)	
( ) Tylenol	( ) Nuts / Fruit	_____
( ) Mint/Fluoride	( ) Milk/Lactose Intolerance	
( ) Red dye_____	( ) 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:_____