Health History

Do You Currently Have or Do you Have a History of any of Following
Please clircle all that apply

High Blood Pressure
typical bp_____
Infective Endocarditis
Respiratory/Asthma/COPD
inhaler use/frequency___
Hepatitis/Liver disease
Thyroid/Hormonal
hyper/hypo
Radiation/Chemo
how long ago___
Cancer/Leukemia
Type_____
white blood cell count ___
Tuberculosis
Mitral Valve Prolapse
Joint Replacement

Heart/Cardiac issues
Pacemaker
Heart Attack/Chest pains
Stroke
Bleeding disorders
platelet count ___
Anxiety/Depression
meds/therapy__ _
Psychiatric Care
TMJ/TMD
Parkinsons
Diabetes/Kidney
last blood sugar___
last AbAlc____
last meal____
Herpes

Rheumatic Fever
Immunocompromised
AIDS/ARC
last CD4 count___
Hypoglycemia
Infectious Disease
Systemic Lupus Erythematosus
G6PD deficiency
what for pain_____
Biphosphanate/bone med
Epilepsy/Seisures/Fainting
how often____
Pregnant/Nursing
how far along___
Cholesterol
Anaphylaxis

Other_____

ALLERGIES please circle all that apply, add anything not listed below
Penicillin, other antibiotic, aspirin, ibuprofen, tylenol, codeine, narcotics,
local anesthesia, latex, sulfa, iodine, seafood,bleach

Other allergies_____
_____

MEDICATIONS please circle all that apply, add anything not listed below
antibiotic, pain medication, aspirin, cortinsone/steroids, blood thinner
blood pressure, hormone, thyroid, birth control, insulin, ulcer nexium
bone related, antidepressants

other meds/purpose_____
_____
_____

PATIENT NAME_____ DATE_____

Patient Signature_____
(Signature of parent or guardian, if patient is a minor)