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MEDICAL HISTORY

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Please select your preferred phone number for contact/confirmation:

☐ Home phone ☐ Work phone ☐ Mobile phone ☐ Other Phone

Patient's Employer and Occupation or School and Grade

_____

_____

For Children/Dependents Only
Please list Parent/Guardian/Subscriber information (Name, Employer, SSN)

_____

_____

_____

Please list second Parent/Guardian/Subscriber information (Name, Employer, SSN)

_____

_____

_____

Does the patient have dental insurance? (If yes, please be sure to bring the information with you, including the subscriber ID # and DOB.)

◯ Yes ◯ No

Whom may we thank for referring you?

Referral Name: _____

Physician's Name, City, Phone, Approximate Date of last Visit:

_____

_____

_____

Pharmacy Name, Address, Phone:

_____

_____

Have you been hospitalized in the last two years? If yes, please explain.

_____

_____

Have you had any surgical procedures? If yes, when and why:

_____

_____

Do you smoke or use a vape? If yes, what do you smoke, how often and for how long.

_____

_____

Are you prone to cold sores? ◯ Yes ◯ No

Women Only: Are you pregnant? ◯ Yes ◯ No

Are you taking birth control? ◯ Yes ◯ No

Please check any/all that apply:

- ☐ *PREMED REQUIRED
- ☐ Active Chemotherapy
- ☐ Allergy-Codeine
- ☐ Allergy-Latex
- ☐ Allergy-Penicillin
- ☐ AntiCoagulants
- ☐ Asthma
- ☐ Blood Pressure H/L
- ☐ DAILY ASPIRIN
- ☐ Dry mouth
- ☐ HIV/AIDS/ARC
- ☐ Heart MVP
- ☐ Immunosupressed
- ☐ MEDICAL CLEARANCE
- ☐ Psychiatric Care
- ☐ Rheumatism
- ☐ Stroke
- ☐ Vertigo/ Menieres
- ☐ ADHD/ADD
- ☐ Addiction: alcohol
- ☐ Allergy-Drugs
- ☐ Allergy-Metals
- ☐ Allergy-Sulfa
- ☐ Anxiety
- ☐ Autism
- ☐ Cancer
- ☐ Dementia
- ☐ Epilepsy/Seizures
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Radiation Treatment
- ☐ SEE MEDICAL HISTORY
- ☐ TB
- ☐ ALLERGY-ANESTHESIA
- ☐ Addiction: drugs
- ☐ Allergy-Erythro
- ☐ Allergy-N-Saids
- ☐ Alzheimer's
- ☐ Artificial Joint
- ☐ Bleeding Disorder
- ☐ Celiac Disease
- ☐ Depression
- ☐ Fainting
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ NO EPI
- ☐ Respiratory/COPD
- ☐ Sjogrens
- ☐ Thyroid Disorder
- ☐ Acid reflux/ Gerd
- ☐ Allergy-Aspirin
- ☐ Allergy-Hay Fever
- ☐ Allergy-Other
- ☐ Anemia
- ☐ Artificial Valve
- ☐ Blood Disease
- ☐ Chrons Disease
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Lupus
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sleep Apnea
- ☐ Ulcers

Please clarify any conditions checked above. Please include any joint replacement dates.

Any special needs or concerns that will help make your visit most comfortable?

Please list any other allergies that you have:

Do you take any of the following? Please check any/all that apply.

☐ Aspirin/Baby Aspirin ☐ Fosamax, Actonel, or Boniva (for Osteoporosis)

Have you ever recieved IV Aredia or Zometa for the treatment of cancer? ◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

☐ *I have answered all questions to the best of my knowledge and will be sure to inform my provider if any of my medical information were to change.

Response Date: _____