MEDICAL HEALTH UPDATE

Name of Patient: ______ DOB: ______

Name of Physician: ______ Phone # ______

Name of any Specialist: ______ Phone# ______

Have you been under a physician's care during the last 2 years? **Y/N** For? ___________________________________
Have you ever had major surgery? **Y/N** For? ____
If female: Are you taking hormones or birth control? **Y/N** Are you pregnant or nursing? **Y/N**
Do you currently take any blood thinners? (ex: Coumadin, Warfarin, Pradaxa, Dabigatran, Xarelto, Plavix, Eliquis, Advil)
Y/N If so, please list them____
Have you had cankers/cold sores on your lips/tongue/body? **Y/N**
Are you now or have you taken any prescription drug in the past year? **Y/N**
What is your pharmacy? ___________________
If you are taking any prescription drugs please name them (or attach list): ____
____
Are you allergic to Penicillin☐Codeine☐Local Anesthetics☐Metal☐Latex☐Other? _______________________________
Have you had, or do you have:

No/Yes
☐☐Heart Attack
☐☐Anemia
☐☐Bleeding Easily
☐☐Blood Transfusions
☐☐Heart Disease
☐☐Artificial Heart Valves
☐☐Congenital Heart Defects
☐☐Rheumatic Heart Defects
☐☐Rheumatic/Scarlett fever
☐☐Heart Murmur
☐☐Heartburn/Gastric Reflux
☐☐Sleep Apnea
☐☐Steroid Therapy
☐☐Kidney Disease
☐☐Autoimmune Disorder
☐☐Chronic Neck Pain
☐☐Chronic Back Pain
☐☐Depression
☐☐Anxiety
☐☐Osteoporosis
☐☐ADD/ADHD
☐☐High Cholesterol

No/Yes
☐☐Low Blood Pressure
☐☐High Blood Pressure
☐☐Angina
☐☐Stroke or Blood Clots
☐☐Pacemaker
☐☐Cancer
☐☐Chemotherapy
☐☐Radiation Therapy
☐☐Malignant Hyperthermia
☐☐Lung Disease
☐☐Tuberculosis
☐☐Emphysema
☐☐Asthma
☐☐Pneumonia/Pleurisy
☐☐Thyroid Disease
☐☐Adrenal Disease
☐☐Diabetes
☐☐Venereal Disease
☐☐Herpes
☐☐AIDS/HIV
☐☐Rheumatoid Arthritis

No/Yes
☐☐Stomach Ulcers
☐☐Stomach/Bowel Disorder
☐☐Eating Disorder
☐☐Difficulty Swallowing
☐☐Alzheimer's/Dementia
☐☐Smoke or Chew Tobacco
☐☐Hearing Difficulty
☐☐Liver Disease
☐☐Cirrhosis of the Liver
☐☐Hepatitis A
☐☐Hepatitis B
☐☐Jaundice
☐☐Drug Dependency
☐☐Glaucoma
☐☐Double Vision/Dizziness
☐☐Epilepsy
☐☐Ear Disorders
☐☐Sinus Trouble
☐☐Psychiatric Problems
☐☐Organ transplant
☐☐Artificial Joints/Pins/Plates
☐☐Seizures/Fainting Spells

Do you have any other disease, condition or factor in your medical history which we should know about? **Y/N**

The above medical profile is complete and accurate. I have not knowingly withheld information and have had the opportunity to ask questions and receive answers regarding the medical profile.

Name: ____ Signature:____
☐Patient ☐Guardian ☐Parent Date:__________________________