PATIENT NAME: _____

PERSONAL MEDICAL HISTORY:

Are you pregnant? ☐ Yes ☐ No ☐ Possibly

(Please check previous or current medical conditions)

☐ None ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Blood Clots/DVT ☐ Cancer ☐ COPD

☐ Depression ☐ Diabetes ☐ Gout ☐ Heart Disease/CAD ☐ Hepatitis ☐ HIV

☐ High Blood Pressure ☐ High Cholesterol ☐ Irregular Heartbeat ☐ Liver Disease ☐ Lung Disease ☐ Osteoporosis

☐ Prostate ☐ Psoriasis ☐ Stomach Ulcer/Reflux ☐ Stroke ☐ Seizures ☐ Thyroid Disease

☐ Vascular Disease ☐ Dental infections or other Unresolved Dental Issues ☐ Other:_____

Have you ever had or been treated for MRSA (Methicillin-resistant Staphylococcus Aurous) or STAPH infection? ☐ No ☐ Yes :Date Cleared _____

Do you have a history of Post-Operative infections? ☐ No ☐ Yes, explain _____

SURGICAL HISTORY: (Please list previous surgeries and dates) ☐ NONE _____

_____

CURRENT MEDICATIONS: (Please list the names of any **prescription medications** which you are presently taking/or provide a list)

_____ _____ _____ _____

_____ _____ _____ _____

MEDICATION ALLERGIES: ☐ None ☐ Yes, name of drug and reaction: _____

ANY METAL ALLERGIES: ☐ None ☐ Yes, what metal? _____

ANY NICKEL ALLERGY: ☐ No ☐ Yes, reaction? _____

SOCIAL HISTORY: Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Hobbies: _____

Smoking History: ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker, _____packs/day for _____years

Alcohol History: ☐ Never ☐ Rare ☐ Social ☐ Daily

FAMILY HISTORY: (Only for parents/offspring & siblings) ☐ None ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Blood Clots/DVT

☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Gout ☐ Heart Disease/CAD ☐ Hepatitis ☐ HIV

☐ High Blood Pressure ☐ High Cholesterol ☐ Irregular Heartbeat ☐ Liver Disease ☐ Lung Disease ☐ Metal Allergy

☐ Osteoporosis ☐ Prostate ☐ Psoriasis ☐ Stomach Ulcer/Reflux ☐ Stroke ☐ Seizures

☐ Thyroid Disease ☐ Vascular Disease ☐ Other: _____

REVIEW OF SYSTEMS: (Please check any of the following issues which you are **CURRENTLY** experiencing)

☐ Fatigue ☐ Weight gain/loss ☐ Fever/Chills ☐ Insomnia ☐ Depression ☐ Anxiety

☐ Vision Changes ☐ Hearing Loss ☐ Sinus Pain ☐ Sore Throat ☐ Mood Swings ☐ Stress

☐ Chest Pain ☐ Palpitations ☐ Edema ☐ Poor Circulation ☐ Hypoglycemia ☐ Diabetes

☐ Cough ☐ Short of Breath ☐ Wheezing ☐ Pneumonia ☐ Thyroid ☐ Hot Flashes

☐ Nausea/Vomiting ☐ Indigestion ☐ Acid Reflux ☐ Stomach Pain ☐ Easy Bruising ☐ Easy Bleeding

☐ Difficult Urination ☐ HIV ☐ Painful Urination ☐ Blood in Urine ☐ Anemia ☐ Blood Clots

☐ Rash ☐ Hives ☐ Sensitive Skin ☐ Easy Scarring ☐ Seasonal Allergies ☐ Food Allergies

☐ Headache ☐ Dizziness ☐ Seizures ☐ Tremor ☐ Frequent Infection ☐ Frequent Urination

THE INFORMATION PROVIDED IS TRUE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND ABILITY. I UNDERSTAND THAT I AM RESPONISIBLE FOR UPDATING THIS INFORMATION, IF ANY OF IT CHANGES, IN A TIMELY FASHION.

PATIENT SIGNATURE: _____ DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____