NEW PATIENT HEALTH HISTORY

Patient's Name

Name and Phone Number of your MEDICAL doctor or Clinic:

Do you have any allergies, if so please list them (Latex,Sulfa Drugs,Sedative,Iodine, ect)

Please list all medications, supplements and over the counter medications you are taking

Are you under doctor's care for any medical condition(s)? Have you been in the hospital in the past year?

Have you ever taken Bisphosphonates such as Actonel, Boniva, or Fosmax or other similar drugs?

- Yes
- No

Indicate which of the following you have had, or have at present. Check all that apply.

☐ ANAPHYLATIC SHOCK
☐ Allergy – Latex
☐ Artificial Valve
☐ Bisphosphonates
☐ Breast Implants
☐ Joint Replacement
☐ Pacemaker
☐ PreMed
☐ Acid Reflux
☐ Allergy – Antibiotics
☐ Allergy – Amoxicillin
☐ Allergy – Aspirin
☐ Allergy – Clindamycin
☐ Allergy - Codeine
☐ Allergy – Erythromycin
☐ Allergy – Gluten
☐ Allergy – Iodine
☐ Allergy – Other
☐ Allergy – Pain Meds
☐ Allergy – Penicillin
☐ Allergy – Seasonal
☐ Allergy – Sulfa
☐ Allergy – Zithromax
☐ Alzheimer's/Dementia
☐ Anemia

SEE BACK

- ☐ Arthritis
- ☐ Asthma
- ☐ Blind/Deaf
- ☐ Blood Thinner/Aspirin
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Chemo/Radiation
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head/Brain Injury
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ Herpes/Cold Sores
- ☐ High Blood Pressure
- ☐ Walker/Wheelchair
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Nervous Disorder
- ☐ NO EPINEPHRINE
- ☐ NO N2O
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea/Disorder
- ☐ STD/HIV/AIDS
- ☐ Stomach Problems
- ☐ Stroke/Heart Attack
- ☐ Thyroid Problems
- ☐ TMJ
- ☐ Tuberculosis
- ☐ Tumors

Any other disease or condition not listed?

FEMALES ONLY

Are you pregnant?

- ☐ Yes
- ☐ No

If yes, please provide us your due date

Are you currently nursing?

- ☐ Yes
- ☐ No