Print Patient's Name _____ Date of Birth _____

Medical History

Please check Yes or No to each of the following and explain:

Yes/No		Yes/No		Yes/No	
☐ ☐	Diabetes	☐ ☐	Back/Neck Problems	☐ ☐	HIV
☐ ☐	Cancer	☐ ☐	Chest Pains	☐ ☐	AIDS
☐ ☐	Heart Disease	☐ ☐	Shortness of Breath	☐ ☐	Hepatitis
☐ ☐	Stroke	☐ ☐	Difficulty Breathing	☐ ☐	Herpes
☐ ☐	Thyroid Disease	☐ ☐	Pacemaker/Defibrillator	☐ ☐	HPV
☐ ☐	Bleeding Disorders	☐ ☐	High Blood Pressure	☐ ☐	Other
☐ ☐	Asthma	☐ ☐	Low Blood Pressure		
☐ ☐	Emphysema	☐ ☐	Heart Attack	**Yes/No**	
☐ ☐	Aneurysm	☐ ☐	Heart Bypass	☐ ☐	Anxiety
☐ ☐	Autoimmune Disease	☐ ☐	Migraine Headaches	☐ ☐	Nervousness
		☐ ☐	Frequent Sinus Infections	☐ ☐	Depression
		☐ ☐	Frequent Ear Infections	☐ ☐	Dental Phobia/Anxiety
		☐ ☐	High Cholesterol		

Yes/No	
☐ ☐	Artificial Heart Valve
☐ ☐	Joint Replacement
☐ ☐	Spinal Fusion
☐ ☐	Any Pins/Screws/Plates
☐ ☐	Rheumatic Fever

ALLERGIES:

Yes/No	
☐ ☐	Latex
☐ ☐	Penicillin
☐ ☐	Lidocaine
☐ ☐	Septocaine
☐ ☐	Vicodin

MEDICATIONS:

OTHER MEDICAL CONDITIONS:

Yes/No	
☐ ☐	
☐ ☐	
☐ ☐	

Patient Signature _____ Date _____