MEDICAL HISTORY

Name:___________________________________Date:_______________Date Updated:_______________

Question	Circle	
Are you currently under the care of a Physician?	Yes	No
Last time seen by a Physician:		
Have you ever had surgery or been in the hospital?	Yes	No
In the last 3 years or less?	Yes	No
Do you premedicate with an antibiotic for dental care?	Yes	No

Do you have or have you had:	Circle	
Back Pain	Yes	No
Sciatica	Yes	No
Neck Pain	Yes	No
Bursitis	Yes	No
Herniated Disk	Yes	No
Area of hand numbness	Yes	No
Area of leg numbness	Yes	No
Do you have any other nerve conditions	Yes	No
Please list:		

Do you have or have you had:	Circle	
Heart Valve Problems	Yes	No
Rheumatic Fever	Yes	No
Rheumatic Heart Disease	Yes	No
Rheumatoid Arthritis	Yes	No
A Heart Murmur	Yes	No
Chest Pain	Yes	No
High Blood Pressure / Low Blood Pressure (current reading________________________)	Yes	No
Do you have any other heart conditions?	Yes	No
Please list:		

Do you have or have you had:	Circle	
HIV or AIDS	Yes	No
Diabetes	Yes	No
Family history of Diabetes	Yes	No
Anemia	Yes	No
Varicose Veins	Yes	No
Edema	Yes	No
Menstrual problems	Yes	No
Abnormal Bleeding	Yes	No
Do you have any other blood conditions:	Yes	No
Please list:		

Do you have or have you had:	Circle	
Tuberculosis	Yes	No
Asthma	Yes	No
Do you smoke	Yes	No
Sinusitis	Yes	No
Shortness of breath	Yes	No
Do you have any other breathing conditions:	Yes	No
Please list:		

Do you have or have you had:	Circle	
Cancer	Yes	No
An Ulcer	Yes	No
Kidney Problems	Yes	No
Hepatitis	Yes	No
Do you have any other organ problems	Yes	No
Please list:		

Do you have or have you had:	Circle	
A stroke	Yes	No
Fainting or Dizziness	Yes	No
Loss of balance	Yes	No
Depression or Anxiety	Yes	No
Claustrophobia	Yes	No
Fatigue	Yes	No
Epilepsy or Convulsions	Yes	No
Psychiatric treatment	Yes	No
Do you have any other nervous system conditions:	Yes	No
Please list:		

Do you have or have you had:		Circle	
Any skin disorders		Yes	No
Any digestive problems		Yes	No
Hernia		Yes	No
Broken bones		Yes	No
An artificial joint		Yes	No
Dentures		Yes	No
Contact Lens		Yes	No
Are you pregnant	N/A	Yes	No

Signature:____