MEDICAL HISTORY & UPDATE: Date:

Name:_____

Are you currently under the care of a physician due to a specific condition/illness? Y / N

Describe:_____

_____

Name of your Physician/Specialist:_____

Please List ALL medications /supplements you are currently taking: (Use the back of this form if needed) Please identify what each medication is for.

Medication:_____for:_____

Medication:_____for:_____

Medication:_____for:_____

Are you allergic to any medications? Y / N Please List:_____

_____

Do you require Pre medication for dental treatment? Y / N WHY?:_____

Do you use tobacco (smoking or chewing)? Y / N

Do you experience an issue with acid reflux or GERD? Y / N

WOMEN ONLY: Are you pregnant? Y / N Due Date:_____

Please indicate if you have experienced or are under treatment for any of the following:

___Artificial joints ___Cancer ___Radiation Treatment ___Epilepsy ___Asthma

___Glaucoma ___Heart Murmur ___Heart Disease ___Mental Health ___Stroke

___HIV ___Liver Disease ___Hepatitis ___Respiratory Problems

___Tuberculosis ___High Blood pressure ___Diabetes ___Blood Thinners

___Pacemaker ___Kidney Disease ___Sinus Problems ___Venereal Disease

Are there any other conditions, allergies or diseases we should be aware of?