***Update \*Office Use Only***

\_\_\_\_\_ \_\_/\_\_/\_\_\_\_

initials date

\_\_\_\_\_ \_\_/\_\_/\_\_\_\_

initials date

\_\_\_\_\_ \_\_/\_\_/\_\_\_\_

initials date

\_\_\_\_\_ \_\_/\_\_/\_\_\_\_

initials date

\_\_\_\_\_ \_\_/\_\_/\_\_\_\_

initials date

***Medications:***

Pain Killers (including aspirin)

Muscle Relaxers

Stimulants

Nerve Pills

Blood Thinners

Tranquilizers

Insulin

Blood Pressure Medication

Bisphosphonates

Others:

SEE ATTACHED LIST

* I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Name (print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

***Questions:***

Do you use tobacco? Y N

How used?

How Often/Much?

How Long?

***Questions For Women:***

Are you pregnant? Y N

How Far Along?

OB Letter Faxed/Emailed? Y N

Are you nursing? Y N

Additional Doctor:

***Allergies:***

Latex

Penicillin

Amoxicillin

Tetracycline

Aspirin

Dental Anesthetics (Including Epinephrine)

Sulfa

Codeine

Others:

***Other surgeries or medical conditions: SEE ATTACHED LIST***

***1.***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***2.***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***3.***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***4.***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***5.***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***6.***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***7.*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***8.*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequent Neck Pain

Back Problems

Cosmetic Surgery

X-ray or Cobalt

Chemotherapy

Asthma

Difficulty Breathing

Diabetes/Hypoglycemia

Leukemia

Anemia

GERD

Bleeding problems

Glaucoma

Osteoporosis

Heart Attack/ Stroke

Heart Surg./Pacemaker

Heart Murmur

High/Low Blood Pressure

Rheumatic Fever

Mitral Valve Prolapse

Artificial Valves

Heart Disease

Congenital Heart Defect

Chest Pains

Scarlet Fever

Nervousness

Thyroid Problems

Kidney Problems

Liver Problems

Respiratory Problems

Sinus Problems

Stomach Problems/ Ulcers

Psychiatric Problems

Venereal Disease

Alcohol/Drug Abuse

Tuberculosis “TB”

Jaw Problems TMJ/TMD

Cancer/Tumors

Shingles

Hepatitis

HIV+/AIDS/ARC

Arthritis/ Rheumatism

Artificial Bones/Joints

Emphysema

Fainting/Seizures/Epilepsy

Severe/Frequent Headaches

***Circle all that apply:***

***Medical History***