ADULT MEDICAL HISTORY Date:_____

Name: _____ Date of Birth: _____ Height_____ Weight ____lbs

Do you have (or have you had) any of the following? Please check the box ☐:

1. Heart / Blood pressure problem

☐ NONE
☐ Heart attack ☐ High blood pressure
☐ Heart Failure ☐ High Cholesterol
☐ Angina (chest pains) ☐ Congestive heart failure
☐ Artificial heart valve ☐ Infective endocarditis
☐ Congenital heart disease
☐ Heart murmur or mitral valve prolapse
☐ Rheumatic fever/ rheumatic heart disease
☐ Pacemaker / Implanted defibrillator
☐ Other _____

2. Neurologic / Nerve problem

☐ NONE
☐ Stroke ☐ TIA (Transient Ischemic Attack)
☐ seizures ☐ epilepsy
☐ Multiple sclerosis ☐Neuropathies
☐Parkinson's ☐Dementia/Alzheimer's
☐ Autism ☐ Other _____

3. Breathing / Lung problems

☐ NONE ☐ Pneumonia
☐ Asthma ☐ Emphysema
☐ COPD ☐ Tuberculosis
☐ Obstructive sleep apnea
☐ Use CPAP/BiPAP
☐ Surgical correction
☐ Uses Oral appliance
☐ Other _____

4. Stomach / Intestine/ Liver Disorder

☐ NONE
☐ Ulcers ☐ Acid Reflux (GERD)
☐ IBS ☐ Crohn's Disease
☐ Celiac ☐ Cirrhosis
☐ Hepatitis
☐A ☐B ☐C ☐D
☐ Other _____

5. Endocrine disorder

☐ NONE
☐ Diabetes: ☐ Type 1 ☐ Type 2
☐ Thyroid disease: ☐ low ☐ high
☐ Other _____

6. Immunosuppressive condition

☐ NONE
☐ Steroid therapy (e.g. Prednisone)
☐ Radiation therapy ☐ SLE (Lupus)
☐ Chemotherapy ☐ HIV
☐ Rheumatoid arthritis ☐ Organ transplant
☐ Sjogren's syndrome ☐ Spleen removed
☐ Other _____

7. Bleeding problems, anemia other blood disease

☐ NO ☐ Yes: Please specify _____

8. Kidney/ urinary disease

☐ NONE ☐ Chronic kidney disease
☐ Bladder problems ☐ Renal failure/ Dialysis
☐ Other _____

9. Artificial joint(s)

☐ NONE
☐ Hip Date placed _____
☐ Knee Date placed _____
☐ Ankle Date placed _____
☐ Shoulder Date placed _____
☐ Other Date placed _____

Other artificial implants, devices or transplants
Describe _____

10. Muscle or bone disease

☐ NONE
☐ Osteoarthritis ☐ Gout
☐ Osteoporosis ☐ Fibromyalgia
☐ Other _____

11. Mental health condition

☐ None ☐ Bipolar disorder
☐ Depression ☐Schizophrenia
☐ PTSD ☐ ADD/ADHD
☐ Panic attacks ☐ Generalized anxiety disorder
☐ Other _____

12. Do you have physical or mental disabilities that may require special care? ☐ Yes ☐ No

☐**Yes** ☐**No** Have you had any serious illness, surgery or been hospitalized? If yes, how long ago?

☐ 0-12 months Specify: _____

☐ 1-5 years Specify: _____

☐ over 5 years, Specify: _____

☐**Yes** ☐**No** Have you ever been treated for cancer? If yes, how was it treated?

☐ Surgery: Site: _____ Diagnosis: _____ when_____

☐ Radiation: Site: _____ Diagnosis: _____ when_____

☐ Chemotherapy: Site: _____ Diagnosis: _____ when_____

☐**Yes** ☐**No** Have you undergone current or past therapy to reduce blood calcium level (bisphosphonate therapy)?
(E.g. Intravenous Aredia , Zometa, Xgeva) Length of time taken: _____

☐**Yes** ☐**No** Have you undergone current or past osteoporosis therapy?
(e.g. Fosamax, Actonel, Boniva) Length of time taken: _____

☐**Yes** ☐**No** Do you use, or have you used, tobacco products?

☐ If in the past, when did you stop? _____

☐ Current: ☐ more than 10 per day ☐less than 10 per day

☐**Yes** ☐**No** Do you drink alcoholic beverages? How many drinks per week_____

☐**Yes** ☐**No** Have you used prescription, street drugs or other substances for recreational purposes?
☐ Cocaine ☐Ecstasy ☐Heroin ☐ Marijuana ☐Meth ☐Other _____

☐**Yes** ☐**No** Do you have any disease or condition not listed here? Pls specify: _____

FEMALES ONLY:

1. Are you or could you be pregnant? ☐Yes ☐No Due date_____
2. Are you nursing? ☐Yes ☐No
3. Are you taking any of the following ? ☐Birth control ☐Fertility drugs ☐Hormone replacement

MEDICATIONS:

Please list all prescriptions, over the counter, supplements, herbal medicine or vitamins you are taking.

	Dose
	Dose
	Dose
	Dose
	Dose
	Dose
	Dose
	Dose

	Dose
	Dose
	Dose
	Dose
	Dose
	Dose
	Dose
	Dose

ALLERGIES

☐ None
☐ Penicillin
☐ Aspirin
☐ Tylenol (acetaminophen)
☐ Other _____

☐ Local anesthesia
☐ Other antibiotics
☐ Ibuprofen
☐ Sulfa Drugs

☐ Metals/ jewelry/ nickel
☐ Latex (rubber)
☐ Other Drug allergy _____
☐ Food allergies _____