## Medical History

Physician's Name: _____ Phone: _____ Last Exam: _____

Women only:

Are you pregnant/nursing? _____ Due Date: _____

If you are currently taking prescription contraceptives do you understand the effects of antibiotics? Yes or No ( circle one )

**Have you been told that you need preventative antibiotics due to a medical condition? Yes or No**

**Please mark your response to indicate if you have had any of the following diseases or problems:**

| Yes or No | | | Yes or No | | | Yes or No | | | Yes or No | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Any changes in your health within the last year? | | | **Skin** | | | **Gastrointestinal** | | | **Other** | | |
| | | | ☐ | ☐ | Hives/Skin Rash | ☐ | ☐ | Acid Reflux/GERD | ☐ | ☐ | Cancer |
| **Musculoskeletal** | | | ☐ | ☐ | Other Skin Lesions | ☐ | ☐ | Irritable Bowel | ☐ | ☐ | Cancer Treatment |
| ☐ | ☐ | Arthritis | | | **Immune** | ☐ | ☐ | Stomach Ulcer | ☐ | ☐ | Tobacco Use |
| ☐ | ☐ | Artificial Joint | ☐ | ☐ | Past Use of Steroids | | | **Endocrine** | ☐ | ☐ | Alcohol Use |
| ☐ | ☐ | Fibromyalgia | ☐ | ☐ | Delayed Healing | ☐ | ☐ | Diabetes | ☐ | ☐ | Chemical Dependency |
| ☐ | ☐ | Lupus | | | **Infections** | ☐ | ☐ | Thyroid Problem | ☐ | ☐ | Recreational/ Illicit Drug Use |
| ☐ | ☐ | Sjogren's Syndrome | ☐ | ☐ | HIV positive/AIDS | | | **Eyes/Ears** | | | Addiction Recovery Date |
| ☐ | ☐ | Osteoporosis | ☐ | ☐ | Sexually Transmitted Diseases | ☐ | ☐ | Glaucoma | | | _____ |
| | | | | | **Hepatic** | ☐ | ☐ | Impaired Vision | | | |
| **Cardiovascular** | | | ☐ | ☐ | Liver Disease | ☐ | ☐ | Impaired Hearing | | | **Allergies** |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Jaundice | | | **Neurogical** | ☐ | ☐ | Aspirin / Ibuprofen |
| ☐ | ☐ | Angina | ☐ | ☐ | Hepatitis | ☐ | ☐ | Epilepsy/Seizures | ☐ | ☐ | Codeine / Narcotics |
| ☐ | ☐ | Heart Attack | | | **Renal** | ☐ | ☐ | Parkinson's Disease | ☐ | ☐ | Penicillin |
| ☐ | ☐ | Irregular Heartbeat | ☐ | ☐ | Kidney Disorder | ☐ | ☐ | Multiple Sclerosis | ☐ | ☐ | Other Antibiotics |
| ☐ | ☐ | Heart Surgery | ☐ | ☐ | Dialysis | ☐ | ☐ | Headaches | ☐ | ☐ | Local Anesthetics |
| ☐ | ☐ | Heart Failure | | | **Respiratory** | | | **Mental Health** | ☐ | ☐ | Acetaminophen/ Tylenol |
| ☐ | ☐ | Damaged Heart Valve | ☐ | ☐ | Asthma | ☐ | ☐ | Bipolar Disorder | ☐ | ☐ | Metals |
| ☐ | ☐ | High Cholesterol | ☐ | ☐ | Emphysema | ☐ | ☐ | Depression | ☐ | ☐ | Latex (circle one) Gloves/Bandages |
| ☐ | ☐ | Heart Infection | ☐ | ☐ | Sleep Apnea | ☐ | ☐ | Anxiety | ☐ | ☐ | Other _____ |
| ☐ | ☐ | Stroke | ☐ | ☐ | Tuberculosis | ☐ | ☐ | Eating Disorder | | | |
| ☐ | ☐ | Anemia | ☐ | ☐ | Difficulty Breathing | ☐ | ☐ | Dementia | | | |
| ☐ | ☐ | Sickle Cell Anemia | | | | ☐ | ☐ | Learning Disorder | | | |
| ☐ | ☐ | Abnormal Bleeding | | | | | | | | | |

Please list any disease, condition, or problem you have that is not listed above.

_____

_____

Have you been treated with any medication for cancer, osteoporosis or any bone disease in the last 12 years?

If so, please list name of medications

_____

_____