PAST MEDICAL HISTORY: (Please circle Yes or No)
Indicate if you have any of the medical problems listed below and add any additional problems not covered in the space provided.

Y / N High Blood Pressure
Y / N Coronary Artery Disease
Y / N Angina (Chest Pain)
Y / N High Cholesterol
Y / N Asthma
Y / N Emphysema/COPD
Y / N Heartburn/GERD
Y / N Kidney/Renal Disease
Y / N History of Cancer
Type: _____
Y / N Arthritis
Y / N Diabetes
Y / N Thyroid Problems

Y / N Depression
Y / N Anxiety
Y / N Bleeding Disorder
Y / N History of Clots in Lungs/Legs
Y / N History of TMJ Dysfunction
Y / N History of Migraine Headaches
Y / N Immune-Deficiency
Y / N Stroke/CVA
Y / N Autoimmune Disease
(Rheumatoid, Lupus, Hashimotos, etc.)
Y / N Other: _____

Y / N Do you have a Living Will or signed Advanced Directive?

SOCIAL HISTORY:
Do you smoke? Yes No Start Date _____/_____/_____ Former Smoker, Quit Date: _____/_____/_____

If yes, how much? _____

Do you drink alcohol? Yes No
If yes, how much 1-3 drinks/week 4-10 drinks/week 10 or more drinks/week

Do you use recreational drugs (marijuana, cocaine, heroin, etc)? Yes No

FAMILY HISTORY: (Please circle if Mother or Father had the following)
Diabetes: Mother or Father or Sibling
Hypertension: Mother or Father or Sibling
Heart Disease: Mother or Father or Sibling
Stroke: Mother or Father or Sibling
Cancer: Mother or Father or Sibling
Other: _____

PAST SURGICAL HISTORY: Please list previous surgeries.

_____

_____

CURRENT MEDICATIONS: Please indicate doses and how often you take.

| Medication | Dose | Frequency | Medication | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

ALLERGIES TO MEDICATIONS:

_____

_____