# PATIENT INFORMATION

What can we do for you? _____ Date _____

Patient's Name: _____ Sex M F D.O.B. ____/____/____

Address: _____ City: _____ State: _____ Zip: ____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____ Spouse, Parent, Guardian, S.O. _____

Who may we thank for referring you to our office?: _____

# MEDICAL HISTORY

Family Physician and Address: _____ Last Physical Exam ____/__/____

| DO YOU HAVE or HAVE YOU EVER HAD: | YES | NO |
|---|---|---|
| 1. hospitalization for illness or injury | ☐ | ☐ |
| 2. allergies (drugs or environmental) | ☐ | ☐ |
| 3. heart problems, or cardiac stent w/in the last 6 months | ☐ | ☐ |
| 4. history of infective endocarditis | ☐ | ☐ |
| 5. artificial heart valve, repaired heart defect (PFO) | ☐ | ☐ |
| 6. pacemaker or implantable defibrillator | ☐ | ☐ |
| 7. artificial prosthesis (heart valve or joints) | ☐ | ☐ |
| 8. rheumatic or scarlet fever | ☐ | ☐ |
| 9. high or low blood pressure | ☐ | ☐ |
| 10. a stroke (taking blood thinners) | ☐ | ☐ |
| 11. anemia or other blood disorder | ☐ | ☐ |
| 12. prolonged bleeding due to a slight cut (INR > 2.4) | ☐ | ☐ |
| 13. emphysema, sarcoidosis (supplemental oxygen) | ☐ | ☐ |
| 14. tuberculosis: | ☐ | ☐ |
| 15. asthma, (how often use an inhaler?) | ☐ | ☐ |
| 16. breathing or sleep problems (i.e. snoring, sinus) | ☐ | ☐ |
| 17. kidney disease | ☐ | ☐ |
| 18. liver disease | ☐ | ☐ |
| 19. jaundice | ☐ | ☐ |
| 20. thyroid, parathyroid disease, or calcium deficiency | ☐ | ☐ |
| 21. hormone deficiency | ☐ | ☐ |
| 22. high cholesterol or taking statin drugs | ☐ | ☐ |
| 23. diabetes (HbA1c =_____) | ☐ | ☐ |
| 24. stomach or duodenal ulcer | ☐ | ☐ |
| 25. digestive disorders (i.e. gastric reflux) | ☐ | ☐ |
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) | ☐ | ☐ |
| 27. arthritis | ☐ | ☐ |
| 28. glaucoma (narrow angle / wide angle) | ☐ | ☐ |
| 29. contact lenses | ☐ | ☐ |
| 30. head or neck injuries | ☐ | ☐ |
| 31. epilepsy, (seizures) weekly, monthly, yearly | ☐ | ☐ |
| 32. neurologic problems (attention deficit disorder) | ☐ | ☐ |
| 33. viral infections and cold sores | ☐ | ☐ |
| 34. any lumps or swelling in the mouth | ☐ | ☐ |
| 35. venereal disease or herpes | ☐ | ☐ |
| 36. hepatitis (type ___) | ☐ | ☐ |
| 37. HIV / AIDS | ☐ | ☐ |
| 38. sleep study for Sleep Apnea, AHI: | ☐ | ☐ |
| 39. using CPAP for Sleep Apnea | ☐ | ☐ |
| 40. radiation therapy | ☐ | ☐ |
| 41. chemotherapy | ☐ | ☐ |
| 42. emotional problems | ☐ | ☐ |
| 43. psychiatric treatment | ☐ | ☐ |
| 44. antidepressant medication | ☐ | ☐ |
| 45. alcohol / recreational drugs | ☐ | ☐ |
| **ARE YOU:** | | |
| 46. presently being treated for any other illness | ☐ | ☐ |
| 47. aware of a change in your general health | ☐ | ☐ |
| 48. taking medication for weight management | ☐ | ☐ |
| 49. taking dietary supplements | ☐ | ☐ |
| 50. often exhausted or fatigued | ☐ | ☐ |
| 51. subject to frequent headaches | ☐ | ☐ |
| 52. smoke or use tobacco products | ☐ | ☐ |
| 53. considered particular | ☐ | ☐ |
| 54. often unhappy or depressed | ☐ | ☐ |
| 55. FEMALE - taking birth control pills | ☐ | ☐ |
| 56. FEMALE – pregnant | ☐ | ☐ |
| 57. MALE – prostate disorders | ☐ | ☐ |

Comments: _____

_____

_____

**List all medications, supplements, and or vitamins taken within the last 2 years.**

| Drug (dosage) | Purpose | Drug (dosage) | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

**ASA I II III IV**