

Patient's Name: _____

Date of Birth ____/____/____ Today's Date ____/____/____

Have you been diagnosed and/or treated for any of these conditions?

(Please Check **All** That Apply)

- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure (hypertension) | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Irregular Heart Beat (arrhythmia) | <input type="checkbox"/> Cancer, please specify: _____ |
| <input type="checkbox"/> Blood Clots | |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Abnormal Immune System |
| <input type="checkbox"/> Kidney Disease Requiring Dialysis | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Inflammatory Bowel Disease (<i>Crohn's Disease or Ulcerative Colitis</i>) | |
| <input type="checkbox"/> Anemia (low blood count/ low iron) | |

- Have you received a Blood Transfusion? Y or N
- Have you received X-ray Treatments for Acne? Y or N
- Have you received Light Treatment for any Kind of Skin Condition? Y or N
- Have you received Radiation Treatment for a Cancer? Y or N

Do You? (Please check **All** that apply)

- | | |
|--|---|
| <input type="checkbox"/> Receive Allergy Shots? | <input type="checkbox"/> Have Any Organ Transplants? |
| <input type="checkbox"/> Have a Pacemaker? | <input type="checkbox"/> Use a tanning bed/booth? |
| <input type="checkbox"/> Have an Artificial Heart Valve? | <input type="checkbox"/> Tend to Form Keloid Scars? |
| <input type="checkbox"/> Have an Abnormal Heart Valve? | <input type="checkbox"/> Tend to Heal Slowly or Poorly? |
| <input type="checkbox"/> Require Antibiotics Prior to Dental Procedures? | <input type="checkbox"/> Have Any Artificial Joints? |
| <input type="checkbox"/> Develop Rashes or Reactions to Bandages, Tapes or Antibiotic Ointments? | |

Do you have any other medical conditions? If yes, please list: _____

Please list all major surgeries: _____

Females Only: (if the patient has **not** undergone changes of puberty, circle n/a) → N/A

- | | |
|---|--------|
| Do you develop frequent yeast infections when taking antibiotics? | Y or N |
| Have you had your uterus removed (hysterectomy)? | Y or N |
| Have you had your ovaries removed? | Y or N |
| Are you menopausal? | Y or N |
| Have you had one or more miscarriages? | Y or N |

Medication History:

Are you allergic to any medications? Y / N If yes, please list: _____

Please list **all** medications you are currently taking (prescriptions, over-the-counter meds, vitamins & herbal supplements):

Do you ever take aspirin, ibuprofen (Motrin, Advil) naproxen sodium (Alleve, Naprosyn), vitamin E supplements, garlic, ginger, ginkgo or ginseng supplements? If yes, please list the items you do take and describe how often. _____

Have you ever had local anesthesia? Y / N Have you ever had a reaction to local or general anesthesia? Y / N

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