Medical History Form

Do you have any of the following Conditions?

Do you have any of the following Conditions?

Adhd/Add *
○ Yes ○ No

Anemia *
○ Yes ○ No

Anxiety *
○ Yes ○ No

ARHYTHMIA *
○ Yes ○ No

Arthritis *
○ Yes ○ No

Artificial Joints *
○ Yes ○ No

Aspirin *
○ Yes ○ No

Asthma *
○ Yes ○ No

Birth Control Pills *
○ Yes ○ No

Blood Clots *
○ Yes ○ No

Blood Disease *
○ Yes ○ No

BULLOUS PEMPHIGOID *
○ Yes ○ No

Cancer *
○ Yes ○ No

Cholesterol *
○ Yes ○ No

Diabetes *
○ Yes ○ No

Dizziness *
○ Yes ○ No

EPI Sensitivity *
○ Yes ○ No

Epilepsy *

HIV *
○ Yes ○ No

Jaundice *
○ Yes ○ No

Kidney Disease *
○ Yes ○ No

Liver Disease *
○ Yes ○ No

LOW BLOOD PRESSURE *
○ Yes ○ No

LYMPHOMA *
○ Yes ○ No

Mental Disorders *
○ Yes ○ No

Migraines *
○ Yes ○ No

Mitral Valve Prolapse *
○ Yes ○ No

Nervous Disorders *
○ Yes ○ No

osteoporosis *
○ Yes ○ No

Other *
○ Yes ○ No

Pacemaker *
○ Yes ○ No

Pregnancy *
○ Yes ○ No

Premedicate *
○ Yes ○ No

prostat enlarged *
○ Yes ○ No

PROSTATE CANCER *
○ Yes ○ No

Radiation Treatment *

Excessive Bleeding *
○ Yes ○ No

FAINT/DIZZINESS *
○ Yes ○ No

Fainting *
○ Yes ○ No

Glaucoma *
○ Yes ○ No

Growths *
○ Yes ○ No

Hay Fever *
○ Yes ○ No

Head Injuries *
○ Yes ○ No

Heart Disease *
○ Yes ○ No

Heart Murmur *
○ Yes ○ No

Heart vlave replmnt *
○ Yes ○ No

Hepatitis *
○ Yes ○ No

High Blood Pressure *
○ Yes ○ No

HIV *
○ Yes ○ No

Reflux *
○ Yes ○ No

Respiratory Problems *
○ Yes ○ No

Rheumatic Fever *
○ Yes ○ No

Rheumatism *
○ Yes ○ No

Sinus Problems *
○ Yes ○ No

Stomach Problems *
○ Yes ○ No

Stroke *
○ Yes ○ No

Thyroid *
○ Yes ○ No

Treachea malasea *
○ Yes ○ No

Tuberculosis *
○ Yes ○ No

Tumors *
○ Yes ○ No

Ulcers *
○ Yes ○ No

Venereal Disease *
○ Yes ○ No

Add unlisted conditions here (one item per entry)

Enter the item not listed here

Do you have any of the following Allergies?

Do you have any of the following Allergies?

Allergies *
○ Yes ○ No

Allergy- Levoquin *
○ Yes ○ No

amoxcillin *
○ Yes ○ No

dogs *
○ Yes ○ No

Erythronycin *
○ Yes ○ No

Hay Fever *
○ Yes ○ No

AMOXICLLINCAVULANATE *

Yes No

ASPIRIN *

Yes No

BESIVANCE/OXOFLOXIN *

Yes No

cats *

Yes No

CELEXA *

Yes No

CIPRO *

Yes No

Codeine Allergy *

Yes No

COMPAZINE *

Yes No

DICLOFENAC *

Yes No

IBUPROPHEN *

Yes No

KEFLEX *

Yes No

Latex allergy *

Yes No

NITROFURAN *

Yes No

Peanut allergy *

Yes No

Penicillin Allergy *

Yes No

Seasonal Allergies *

Yes No

Shellfish Allergy *

Yes No

SULFA DRUGS *

Yes No

SULFER *

Yes No

Add unlisted allergies here (one item per entry)

Enter the item not listed here

I have disclosed all my allergies. *

Are you taking any of the following Medications?

Are you taking any of the following Medications?

ADDERAL *

Yes No

albuterol *

Yes No

ALBUTEROL INHALER *

Yes No

alendronate *

Yes No

ALFUZOSIN HCL *

Yes No

ALLEGRA *

Yes No

IUD *

Yes No

JENUMET *

Yes No

KLONOPIN *

Yes No

Labetalol *

Yes No

lasarta *

Yes No

LATANAPROST *

Yes No

alprazolamo *

Yes No

AMLODIPINE *

Yes No

AMLODIPINE BESYLATE TAB *

Yes No

AMLODIPINE-BENZEPRIL *

Yes No

AMLODIPNE *

Yes No

AMOXICILLIN *

Yes No

ARTHYTHIMIA *

Yes No

ASPIRIN *

Yes No

ATEROLO *

Yes No

ATORVASTASTIN *

Yes No

ATOVAQUONE *

Yes No

Atrovastatin *

Yes No

avodart *

Yes No

Baby Aspririn *

Yes No

bactrim *

Yes No

BAYER *

Yes No

Biktrarvy 50/200/25 *

Yes No

BLISOVI *

Yes No

breo ellipta *

Yes No

BRIMONIDINE TARTRATE *

Yes No

LENVINE *

Yes No

LEUCOVORIN *

Yes No

LEXAPRO *

Yes No

LIPITOR *

Yes No

Lisinopril 10mg *

Yes No

LOSARTAN *

Yes No

METFORMAN *

Yes No

METFORMIN *

Yes No

methlmazole *

Yes No

methotrexate *

Yes No

METHYLPREDNISNOL *

Yes No

METOPROLOL *

Yes No

METOPROLOL TART TAB *

Yes No

mounjaro *

Yes No

MYCHOPHENOLATE *

Yes No

NAPROXEN *

Yes No

NETFORMIN *

Yes No

NIACINAMIDE *

Yes No

NORVASE *

Yes No

NUCYNTA *

Yes No

BUPROPHIN XL *
Yes No

BYSTOLIC *
Yes No

BYSTOLIE *
Yes No

calcium *
Yes No

CARBATRD *
Yes No

CAREONE ESSENTIAL VITAMIN *
Yes No

CARVEDILOL *
Yes No

CENTRUM SILVER MEN *
Yes No

CISINOPRIL *
Yes No

CITRACAL *
Yes No

CITRACAL-CALCIUM D3 *
Yes No

CLINDAMYCIN *
Yes No

colace *
Yes No

COLRITE *
Yes No

CoQ-10 *
Yes No

COSAMIN DS *
Yes No

CRESTOL *
Yes No

CYBALTA *
Yes No

CYCLOBENZAPRINE *
Yes No

D3-1000 *
Yes No

DESVENLAFAXINE *
Yes No

NURTEC *
Yes No

Omega 3 acid *
Yes No

Omeprazole *
Yes No

OMEPROSOL *
Yes No

ONDANSETRON *
Yes No

ORAL CONTRACEPTIVE *
Yes No

PAXIL *
Yes No

PLAVIX *
Yes No

PNILOSEC *
Yes No

potassium *
Yes No

potassium erio *
Yes No

PRE NATALS *
Yes No

PREDNISONE *
Yes No

proxetine *
Yes No

PROZAC *
Yes No

RAMPRIL *
Yes No

REFRESH OPTIVE *
Yes No

restasis *
Yes No

RIVELSA ORAL CONTRACEPTIVE *
Yes No

ROPINIROLE HCL *
Yes No

ROSUVASTATIN *
Yes No

DICLOFENAC *
Yes No

DORZOLAMIDE HCL *
Yes No

DOXYCYCLINE *
Yes No

DOXYCYCLINE HYCLATE *
Yes No

ECOTRIN *
Yes No

EDARBI *
Yes No

Eliquis *
Yes No

ENALAPRIL *
Yes No

ENALAPRIL MATEATE *
Yes No

ESCITALOPRAM *
Yes No

EZETIMIBE *
Yes No

FLAXSEED OIL *
Yes No

flomax *
Yes No

FLOUER BID *
Yes No

FOLIC ACID *
Yes No

FOLOIC ACID *
Yes No

GABAPENTIN *
Yes No

GARLIC PILL *
Yes No

GEMFIBROZIL *
Yes No

GLIMEPERIDE *
Yes No

SEMAGLUTIDE *
Yes No

SERTRALINE *
Yes No

SERTRALINE HCL *
Yes No

SILDENAFIL CITRATE *
Yes No

SIMPOLANA INFUSION *
Yes No

SIMVASTATIN *
Yes No

SIMVASTIN *
Yes No

SINGULAR *
Yes No

spironolactone *
Yes No

statin *
Yes No

SYNTHROID *
Yes No

TAMOXIFEN *
Yes No

Tamsulosin *
Yes No

tenofovir *
Yes No

TIMOLOL MALEATE *
Yes No

topamax *
Yes No

TOPIRAMATE *
Yes No

TOPROL XL *
Yes No

toujeo *
Yes No

TRAZADONE *
Yes No

GLUCOAMINE *
Yes No

HCTZ *
Yes No

HUMALIM *
Yes No

HYDRALAZINE *
Yes No

HYDROCHLOROTHLAZIDE *
Yes No

IBUPROPHEN *
Yes No

IMMITREX *
Yes No

INVOCANA *
Yes No

IRBESARTAN *
Yes No

iron *
Yes No

ISOSORBIDE MONO TAB *
Yes No

trulicity *
Yes No

tylenol *
Yes No

uroxathal *
Yes No

URSODIOL *
Yes No

VENLAFAXINE *
Yes No

VIBYRD *
Yes No

Vitamin B - NH *
Yes No

VITAMIN D3 *
Yes No

VITAMINS *
Yes No

WELLBRUTRIN *
Yes No

XANAX *
Yes No

ZOLOFT *
Yes No

Add unlisted medications here (one item per entry)

Enter the item not listed here

I have disclosed all medications I currently take. *

Additional Questions

Additional Questions

Date of last exam

MM/dd/yyyy

Have you had any serious illness, operation, or hospitalization in the past 5 years? *
Yes No

Are you on a special diet? *
Yes No

Have you had any head or neck injuries? *

Yes No

Do you experience any tooth sensitivity? *

Yes No

Do you grind your teeth? *

Yes No

Do you smoke or chew tobacco? *

Yes No

Patient's First Name *

Patient's Last Name *

Sign Here

Signature *

Date *

10/30/2023