

HEALTH HISTORY

Name: _____ Age _____ Male _____ Female _____ Date of birth ____/____/____

Have you had any serious illness, operation or have you been hospitalized in the past 5 years? Y or N
If YES, please explain: _____

➤ **GENERAL**

1. Are you currently under the care of a physician? Y or N
2. For what condition? _____

Do you have or have you had any of the following conditions? (Please circle "Yes" or "No")

Y or N Diabetes? Controlled by Diet Insulin Y or N Hypothyroidism Y or N Hyperthyroidism
Y or N Arthritis Y or N Kidney Conditions Y or N Dialysis
Y or N Headaches Y or N Migraine Y or N Epilepsy Y or N Seizures Y or N Strokes
Y or N Liver condition Y or N Hepatitis A, B, Y or N Venereal Disease
Y or N Positive for HIV or AIDS Y or N Mouth Sores or Lesions?
Y or N History of Eating Disorder or Acid Reflux? Y or N TMJ or TMD
Y or N Do you have any Artificial Joint Replacements? Date placed: _____ Which joint: _____
Y or N Cancer? Type: _____ Chemo or Radiation Y or N

Women: Are you or is there a chance you are pregnant? Y or N Week: _____ Due date: _____
Nursing? Y or N

➤ **CIRCULATION** (Please check box that applies)

Blood Pressure: High Normal Low Blood disorder Anemia Slow Clotting
Date last checked: _____ Pacemaker Shunt Date Placed: _____
 Heart Trouble Heart Attack Angina Heart Surgery Bypass Valve Replaced
 Rheumatic Fever Scarlet Fever Mitral Valve Prolapse Heart Murmur

➤ **RESPIRATORY**

Y or N Chronic Lung Disease Y or N Tuberculosis
Y or N Asthma Y or N Persistent cough or cough up blood?
Y or N Emphysema Y or N Sinus Trouble
Y or N Do you currently use Tobacco products? Cigarettes Smokeless tobacco Pipe Cigars
If yes, how long have you been using this product? _____ How often? _____

➤ **DRUGS AND MEDICATIONS**

Have you had any allergic reactions to the following? (Please circle "Yes" or "No")

Y or N - Aspirin Y or N - Erythromycin
Y or N - Latex Y or N - Penicillin
Y or N - Fluoride Y or N - Sulfa Drugs
Y or N - Codeine or Pain Medications Y or N - Dental Anesthetics
Y or N - Non-Steroidal Anti-inflammatory Y or N - Gluten
Y or N Any other Medications or Antibiotic, Allergies? Please list: _____
Please list any other Allergies (Food, Metals, Etc.) _____

Y or N Are you taking any Prescription Medications? Please list: _____

Y or N Are you taking any Over-The-Counter drugs or Herbals? Please list: _____

Y or N Have you or are you being treated for any drug or alcohol addiction?

Y or N Have you or are you being treated for any problems with mental health?

I certify that all of the above information is correct and I authorize its' release as required for the administration of my treatment.

Signature of Responsible Party _____ **Today's Date:** _____