Medical History Form - Body Systems

Do you have these or any other Skeletal /Muscular or Skin issues?

Artificial Joints *

○ Yes ○ No

Rheumatism *

○ Yes ○ No

Tumors *

○ Yes ○ No

Add Unlisted Dermal, Muscular, Skeletal Items Here

Enter the item not listed here

Do you have these or any other Organ (Lungs, Kidney, Liver, Stomach, etc) issues?

Jaundice *

○ Yes ○ No

Kidney Disease *

○ Yes ○ No

Liver Disease *

○ Yes ○ No

Sinus Problems *

○ Yes ○ No

Stomach Problems *

○ Yes ○ No

Thyroid Disease *

○ Yes ○ No

Ulcers *

○ Yes ○ No

Add Unlisted Organs (Liver, GI, Lungs, Kidneys, Reproductive) Items Here

Enter the item not listed here

Do you have these or any other Cardiovascular Issues (Heart, Blood flow, Veins, Arteries, etc)?

Blood Disease *

○ Yes ○ No

Heart Murmur *

○ Yes ○ No

Excessive Bleeding *

Pacemaker *

Yes No

Yes No

Heart Disease *

Yes No

Respiratory Problems *

Yes No

Add Unlisted Cardiovascular, Circulatory Items Here

Enter the item not listed here

Do you have these or any other Neural Issues (Brain, Spine, Nerves, etc)?

Dizziness *

Yes No

Head Injuries *

Yes No

Epilepsy *

Yes No

Nervous Disorders *

Yes No

Add Unlisted Nervous System Items Here

Enter the item not listed here

Are you allergic to these or any other substances (Medications, Materials, Food, etc)?

Allergies *

Yes No

Allergy - Other *

Yes No

Allergy - Aspirin *

Yes No

Allergy - Penicillin *

Yes No

Allergy - Codeine *

Yes No

Allergy - Soy *

Yes No

Allergy - Erythro *

Yes No

Allergy - Sulfa *

Yes No

Allergy - Hay Fever *

Yes No

Allergy- Peanuts *

Yes No

Allergy - Latex *

Yes No

Allergy- Tree nuts *

Yes No

Allergy - Milk *

◯ Yes ◯ No

Amoxicillin *

◯ Yes ◯ No

Food Coloring *

◯ Yes ◯ No

Add Unlisted Allergies Items Here

What else are you allergic to:

Enter the item not listed here

☐ I have disclosed all my allergies. *

Do you have any other conditions we should know about?

*Pre-Med *

◯ Yes ◯ No

Fainting *

◯ Yes ◯ No

ADHD *

◯ Yes ◯ No

HIV *

◯ Yes ◯ No

Acid reflux *

◯ Yes ◯ No

Mental Disorders *

◯ Yes ◯ No

Autistic Spectrum *

◯ Yes ◯ No

Other *

◯ Yes ◯ No

Congenital Diseases *

◯ Yes ◯ No

Pregnancy *

◯ Yes ◯ No

Developmt Disorders *

◯ Yes ◯ No

Radiation Treatment *

◯ Yes ◯ No

Rheumatic Fever *

◯ Yes ◯ No

Add Unlisted Other Items Here

Enter the item not listed here

Additional Questions

Additional Questions

Are you currently under the care of a physician? *

◯ Yes ◯ No

Are you on a special diet? *

◯ Yes ◯ No

Have you had any serious neck or head injuries? *

◯ Yes ◯ No

Do you experience any pain in your teeth? *

◯ Yes ◯ No

Do you experience any tooth sensitivity? *

◯ Yes ◯ No

Do you grind your teeth? *

◯ Yes ◯ No

Do you suffer from TMJ? *

◯ Yes ◯ No

Do you use controlled substances? *

◯ Yes ◯ No

Do you use tobacco? If so, how frequently? *

◯ Yes ◯ No

Taking any oral contraceptives? *

◯ Yes ◯ No

Do you have any other health issues or concerns that were not listed? *

◯ Yes ◯ No

Patient's First Name *

Patient's Last Name *

Sign Here

Date *

02/20/2023

Signature *