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PATIENT MEDICAL HISTORY

Patient's Name _____ Date of Birth _____

1. Has there been any change in your health within the past year? ☐ Yes ☐ No

2. Are you now under the care of a physician? ☐ Yes ☐ No
   If yes, what condition is being treated? _____

3. Do you have, or have you had, any of the following?

☐ Sleep Apnea on CPAP	☐ Treatment to Head or Neck	☐ Immune Deficiency	☐ Lung Disease
☐ Asthma	☐ Diabetes	☐ Mental or Nervous Disorder	☐ Arthritis
☐ Chest Pain	☐ Kidney Disorder	☐ Alcoholism or Drug Abuse	☐ Cancer
☐ Heart Murmur	☐ Heart Disease (Heart Attack, Stroke)	☐ Previous Injury to Jaw or Face	☐ Glaucoma
☐ Rheumatic Fever	☐ Thyroid or other Glandular Disorder	☐ Ulcers	☐ ADHD/FASD
☐ Rheumatic Heart Disease	☐ Liver Disease, Hepatitis or Jaundice	☐ Abnormal Bleeding	Other_____
☐ Autism Spectrum Disorders	☐ Speech Impairment	☐ Blood Disorders	
☐ High / Low Blood Pressure	☐ Epilepsy / Seizures / Radiation		

4. Are you presently taking, or have you recently taken, any medication or drugs?

☐ **ASPIRIN/ASA**	☐ Heart Pills	☐ Steroids/Cortisone
☐ Antidepressants	☐ Blood Pressure Pills	☐ Insulin
☐ Antibiotics	☐ Anticoagulants (Blood Thinner Pills)	☐ Other _____

4a. Current Medications (please list ***all*** prescription and non-prescription medications)

Medication Name	Dose
_____	_____
_____	_____
_____	_____

4b. Are you currently taking any supplements, specifically Gingko, Garlic or Ginseng? ☐ Yes ☐ No
If yes, which one(s)? _____

5. Have you ever had an allergic reaction to any drugs/medications or foods, specifically nuts or eggs? ☐ Yes ☐ No
If yes, which one(s)? _____

6. Have you ever had any serious illnesses, operations or hospitalizations that as yet have not been mentioned? ☐ Yes ☐ No

7. Have you ever had a general anaesthetic? ☐ Yes ☐ No
If yes, were there any problems? _____

8. Height _____ Weight _____

9. Women: Are you pregnant or nursing: ☐ Yes ☐ No

10. Do you smoke or vape? ☐ Yes ☐ No If you answered Yes: How many years _____ Amount_____

11. Do you drink alcohol? ☐ Yes ☐ No If you answered Yes: ☐ Rarely ☐ Socially ☐ Daily

12. Do you have any other medical conditions that are not listed above? ☐ Yes ☐ No

Signature _____ **Date** _____