NAME _____

I prefer to be addressed as _____

**HEALTH HISTORY . . .**

CURRENT MEDICATIONS *(Prescriptions and Over the Counter including herbal supplements)*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

**HAVE YOU EVER TAKEN**

| Y | N | |
|---|---|---|
| ❑ | ❑ | Blood Thinners ex. Coumadin, Warfarin |
| ❑ | ❑ | Steroids ex. Prednisone, Cortisone, etc. |
| ❑ | ❑ | Anxiety medication |
| ❑ | ❑ | Cancer medication such as Aredia, Zometa, etc. |
| ❑ | ❑ | Osteoporosis/Bone Density Medication such as Fosamax. Boniva, Actonel, etc. |
| ❑ | ❑ | Pre-medication for Dental Appointments |

❑ ❑ Do you smoke tobacco? How much?_____

❑ ❑ Do you chew tobacco? How much?_____

❑ ❑ Have you ever been hospitalized in the last 5 years?

**Have you ever had any of the following medical conditions?**

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| ❑ | ❑ | Abnormal Bleeding/ Hemophilia | ❑ | ❑ | HIV Positive/AIDS |
| ❑ | ❑ | Acid Reflux/Heart Burn | ❑ | ❑ | Hypoglycemia/ Low Blood Sugar |
| ❑ | ❑ | Anemia | ❑ | ❑ | Joint Replacement ex. Knee, Hip |
| ❑ | ❑ | Anxiety/Depression | ❑ | ❑ | Kidney Stones/ Kidney Disease |
| ❑ | ❑ | Arthritis | ❑ | ❑ | Memory Loss |
| ❑ | ❑ | Artificial Heart Valve | ❑ | ❑ | Neck/Back Pain |
| ❑ | ❑ | Asthma | ❑ | ❑ | Physical Challenges that require accommodation ex. Wheelchair, etc. |
| ❑ | ❑ | Auto-Immune, Skin Eczema, Lupus | ❑ | ❑ | Radiation Treatments |
| ❑ | ❑ | Cancer | ❑ | ❑ | Seizures |
| ❑ | ❑ | Chemotherapy Treatments | ❑ | ❑ | Shingles |
| ❑ | ❑ | Cold/Canker Sores | ❑ | ❑ | Shortness of Breath |
| ❑ | ❑ | Congenital Heart Defect | ❑ | ❑ | Sinus Problems |
| ❑ | ❑ | Diabetes | ❑ | ❑ | Snoring/Sleep Apnea |
| ❑ | ❑ | Drug/Alcohol Dependence | ❑ | ❑ | Stomach Ulcers |
| ❑ | ❑ | Eating Disorder | ❑ | ❑ | Stroke |
| ❑ | ❑ | Headaches (frequent) | ❑ | ❑ | Tuberculosis Exposure |
| ❑ | ❑ | Hearing Impaired/Loss | ❑ | ❑ | Other:_____ |
| ❑ | ❑ | Heart Attack | | | |
| ❑ | ❑ | Heart Murmur | | | |
| ❑ | ❑ | Heart Surgery ex. Bypass, Pacemaker | | | |
| ❑ | ❑ | Hepatitis | | | |
| ❑ | ❑ | High/Low Blood-Pressure | | | |

Women, are you... Pregnant? ❑Y ❑N # of Weeks Taking oral contraceptives? ❑Y ❑N Nursing? ❑Y ❑N

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING...**

❑ Anesthetic ❑ Aspirin ❑ Codeine ❑ Latex ❑ Metals ❑ Penicillin ❑ Tetracycline

❑ Other:_____

*I have reviewed the information above and have answered to the best of my knowledge.*

*I understand that it is my responsibility to inform Dr. Jackson or his staff of any changes to my health status.*

Signature:_____ Date:_____ Reviewed by:_____

**PERIODIC UPDATES . . .**

| DATE | CHANGE | SIGNATURE | REVIEWED BY |
|---|---|---|---|
| | | | |
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