Medical History Form

Are you taking any of the following Medications?

Are you taking any of the following Medications?

Acarbose *
◯ Yes ◯ No

Accutane *
◯ Yes ◯ No

Aciphex *
◯ Yes ◯ No

Actemra *
◯ Yes ◯ No

Adderall *
◯ Yes ◯ No

Adderall XR *
◯ Yes ◯ No

Adipex *
◯ Yes ◯ No

Albuterol Inhaler *
◯ Yes ◯ No

Alogliptin *
◯ Yes ◯ No

Ambien *
◯ Yes ◯ No

Amoxicillan Clavulan *
◯ Yes ◯ No

Amoxicillin *
◯ Yes ◯ No

Areds with Lutein *
◯ Yes ◯ No

Aspirin *
◯ Yes ◯ No

Atenolol(Tenormin) *
◯ Yes ◯ No

Atorvastatin *
◯ Yes ◯ No

Baclofen *
◯ Yes ◯ No

Bactrum *

Lorazepam *
◯ Yes ◯ No

Losartan *
◯ Yes ◯ No

Losartan Potassium *
◯ Yes ◯ No

Lotemax *
◯ Yes ◯ No

Metaxalone *
◯ Yes ◯ No

Metformin *
◯ Yes ◯ No

Methylpresnisolone *
◯ Yes ◯ No

Metoclopramide *
◯ Yes ◯ No

Minoxidil *
◯ Yes ◯ No

Miralax *
◯ Yes ◯ No

Morphine *
◯ Yes ◯ No

Nabumetone *
◯ Yes ◯ No

Naproxen *
◯ Yes ◯ No

Nasonex *
◯ Yes ◯ No

Penicillan *
◯ Yes ◯ No

Plavix *
◯ Yes ◯ No

Pradaxa *
◯ Yes ◯ No

Praluent Pen *

○ Yes ○ No

○ Yes ○ No

Capron *

○ Yes ○ No

Clindamycin Toetinoi *

○ Yes ○ No

Clomipramine *

○ Yes ○ No

Clopidogrel *

○ Yes ○ No

Coumadin *

○ Yes ○ No

Cymbalta /duloxetine *

○ Yes ○ No

Cyproheptadine *

○ Yes ○ No

Dexamethazone *

○ Yes ○ No

Dexmethylpheridate *

○ Yes ○ No

Digoxin *

○ Yes ○ No

Eliquis *

○ Yes ○ No

Flomax *

○ Yes ○ No

Fosamax *

○ Yes ○ No

Gabapentin *

○ Yes ○ No

Geritol *

○ Yes ○ No

Glyburide *

○ Yes ○ No

Heptron *

○ Yes ○ No

Humira *

○ Yes ○ No

Hydrocodone Acetamin *

○ Yes ○ No

Ibuprofen *

○ Yes ○ No

Propranolol *

○ Yes ○ No

Risperidone *

○ Yes ○ No

Rybelsus *

○ Yes ○ No

Savaysa *

○ Yes ○ No

Simvastatin *

○ Yes ○ No

Sinokot *

○ Yes ○ No

Sodium Oxybate *

○ Yes ○ No

Testosterone *

○ Yes ○ No

Tramadol *

○ Yes ○ No

Valium *

○ Yes ○ No

Varenilcine *

○ Yes ○ No

Vienva *

○ Yes ○ No

Vitamin B Complex *

○ Yes ○ No

Vitamin B-1 *

○ Yes ○ No

Vitamin D3 K2 *

○ Yes ○ No

Warfarin *

○ Yes ○ No

Wegovy *

○ Yes ○ No

Wellbutrin *

○ Yes ○ No

Xanax *

○ Yes ○ No

Xarelto *

○ Yes ○ No

Indapamide *

◯ Yes ◯ No

Insulin *

◯ Yes ◯ No

Lacta Loose *

◯ Yes ◯ No

Lasix/furosemide *

◯ Yes ◯ No

Leflunomide *

◯ Yes ◯ No

Levalbuterol *

◯ Yes ◯ No

Levitracitam *

◯ Yes ◯ No

Levobunolol *

◯ Yes ◯ No

Levocarnitin *

◯ Yes ◯ No

Levothyroxin *

◯ Yes ◯ No

Lexapro *

◯ Yes ◯ No

Lisinopril *

◯ Yes ◯ No

Lithium ER *

◯ Yes ◯ No

Lomotrigine *

◯ Yes ◯ No

Add unlisted medications here (one item per entry)

Enter the item not listed here

☐ I have disclosed all medications I currently take. *

Do you have any of the following Allergies?

Do you have any of the following Allergies?

Adderall *

◯ Yes ◯ No

Anesthetic Allergy *

Meloxicam *

◯ Yes ◯ No

Minoxidil *

○ Yes ○ No

○ Yes ○ No

Aspirin Allergy *
○ Yes ○ No

Bisphosphonates *
○ Yes ○ No

Bupropion *
○ Yes ○ No

Caffeine *
○ Yes ○ No

Cefazolin *
○ Yes ○ No

Cefepime *
○ Yes ○ No

Cetazolin *
○ Yes ○ No

Clavulanate Potassium *
○ Yes ○ No

Codeine Allergy *
○ Yes ○ No

Dispiredol *
○ Yes ○ No

epinephrine *
○ Yes ○ No

Fentonyl *
○ Yes ○ No

Fluticanone *
○ Yes ○ No

Gemfibrozil *
○ Yes ○ No

Heparin *
○ Yes ○ No

Ibuprofen Allergy *
○ Yes ○ No

Iodine Allergy *
○ Yes ○ No

Latex Allergy *
○ Yes ○ No

Narcotics *
○ Yes ○ No

Oxycodone *
○ Yes ○ No

Penicillin Allergy *
○ Yes ○ No

Pneumovax *
○ Yes ○ No

Quinine *
○ Yes ○ No

Sulfa Allergy *
○ Yes ○ No

Theopentathal *
○ Yes ○ No

Tramadol *
○ Yes ○ No

Vicodin *
○ Yes ○ No

Vyvanse *
○ Yes ○ No

Add unlisted allergies here (one item per entry)

Enter the item not listed here

☐ I have disclosed all my allergies. *

Do you have any of the following Conditions?

Do you have any of the following Conditions?

AFIB *
○ Yes ○ No

AIDS *
○ Yes ○ No

Artificial <3 Valve *
○ Yes ○ No

Artificial Joints *
○ Yes ○ No

Cerebral Stent *
○ Yes ○ No

Diabetes *
○ Yes ○ No

Epilepsy *
○ Yes ○ No

Excessive Bleeding *
○ Yes ○ No

Hashimoto's Disease *
○ Yes ○ No

Heart Problems *
○ Yes ○ No

Heart Valve Prolapse *
○ Yes ○ No

Hepatitis *
○ Yes ○ No

hiatal hernia *
○ Yes ○ No

High Blood Pressure *
○ Yes ○ No

High Cholesterol *
○ Yes ○ No

HIV *
○ Yes ○ No

Hypertension *
○ Yes ○ No

Multiple Sclerosis *
○ Yes ○ No

Pacemaker *
○ Yes ○ No

Pregnancy *
○ Yes ○ No

schatski's ring *
○ Yes ○ No

Shortness of Breath *
○ Yes ○ No

Add unlisted conditions here (one item per entry)

Enter the item not listed here

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

Date *

01/31/2024

Signature *