Medical History

Patient Name: _____

1) Are you being treated for any medical conditions by a physician? _____ **Yes** **No**
_____
_____

2) Have you been Hospitalized recently? _____ **Yes** **No**
_____

3) Current Medications: _____ **Yes** **No**
_____
_____

4) Have you ever had any Surgery? If yes, please explain: _____ **Yes** **No**
_____
_____

5) Do you have any Allergies? (Food, drug, etc.) _____ **Yes** **No**

6) Women: Are you pregnant now? Weeks: _____ Due date: _____ **Yes** **No**

7) Tobacco Use: **Yes** **No** Recreational Drug Use: **Yes** **No** Alcohol Use: **Yes** **No**: _____

8) Osteoporosis Treatment: Bisphosphonates (Fosamax, Actonel), Prolia _____ **Yes** **No**

9) Sleep apnea **Yes** **No** If yes do you wear a CPAP machine **Yes** **No**

Please indicate with a check mark √ if you ever had or been treated for any of the following:

Rheumatic Fever	_____	Jaundice	_____	Chronic Cough	_____	Mononucleosis	_____
Heart Murmur	_____	Hepatitis	_____	Asthma/ Sinus	_____	Epilepsy	_____
Mitral Valve Prolapse	_____	Liver Problems	_____	Tuberculosis	_____	Psychiatric Care	_____
Heart Disease	_____	Bleeding Problems	_____	Breathing Problems	_____	Malignant Hyperthermia	_____
Heart Attack	_____	Ulcers	_____	Thyroid Problems	_____	Cancer	_____
Angina	_____	High Blood Pressure	_____	Diabetes	_____	Radiation or Chemotherapy	_____
Weight loss medication (Ozempic, Wegovy, Saxenda)	_____	Anxiety	_____	Kidney Disease	_____		

Any history with sedation problems ? Yes No

Are there any other conditions not previously noted that we should be aware of? _____
_____

Patient or Guardian's Signature: _____

Office Use:
_____
_____
_____
_____
_____

Reviewed by:_____ Date:_____