*Patient Name*_____ *Date*_____

General Information

How do you rate your health? (Check one)

☐ Excellent ☐ Good ☐ Fair ☐ Poor

What health concerns, symptoms, and/or complaints would you like to be discussed? (list below:)

1.

2.

3.

Date of last exam:_____

Are you under a physician's care now? If yes, why?

_____

_____

_____

_____

_____

List of Surgeries:

Date:_____ Surgery:_____

Date:_____ Surgery:_____

Date:_____ Surgery:_____

Date:_____ Surgery:_____

Date:_____ Surgery:_____

List of Current Medications and Dosages:

Name:	Dose:	Reason:

*Patient Name*_____ *Date*_____

Please List Food and Medication Allergies:

_____

_____

_____

_____

Blood Type:_____ **Ancestry:**_____ (German, Irish, Italian, Mexican, ie…)

Dental

Do you have/had any "silver" fillings? □ Yes □ No

If yes, how many?_____

Have you ever had a root canal? □Yes □No

If yes, which teeth?_____

Which type of root canal filling material was used?_____

Do you have a metallic taste in your mouth? □ Yes □ No

Have you been diagnosed with any of the following:

Cavitations: □ Yes □ No

Periodontal Disease: □ Yes □ No

Gingivitis: □ Yes □ No

Have you ever had Invisilign clear braces?_____

Tobacco/Drugs

Do you smoke?_____ How many years?_____

Please mark all that apply

□ Cigarettes

□ Cigars

□ Pipe

*Patient Name*_____ *Date*_____

Do you chew tobacco?_____

Have you been exposed to second hand smoke?_____

Do you have a drug habit? □ Yes □ No

Recreational or Pharmaceutical (please circle all that apply)

If yes, explain:_____

_____

_____

Family Medical History

Please check if your blood relatives have had any of the following:

☑	**Disease**	**Relationship**	**Deceased or Alive**
	Arthritis, Gout		
	Asthma, Hay fever		
	Autoimmune Diseases (RA, Hashimoto's, Lupus, MS, etc.)		
	Cancer-type:_____		
	Chemical Dependency		
	Diabetes-type (Please circle) Type I or Type II		
	GI (IBS, GERD, Ulcers, etc.)		
	Heart Disease, Strokes		
	High Blood Pressure		
	Kidney Disease		
	Obesity		
	Neurological (Alzheimer's, Parkinson's, Depression, Anxiety, Autism, OCD, ADD)		
	Thyroid Disease/Disorder		

Personal Medical Questionnaire

Autoimmune Disorders-Please check any that apply

☑	**Autoimmune Disorders:**	☑	**Autoimmune Disorders:**
	Celiac Disease		Primary Biliary Cirrhosis
	Crohn's Disease		Rheumatoid Arthritis
	Grave's Disease		Scleroderma
	Hashimoto's Thyroiditis		Sjogren's Disease
	Lupus		Type 1 Diabetes
	Mixed Connective Disease		Ulcerative Colitis

Patient Name_____ Date_____

Cardiovascular Disorders-Please check all that apply

☑	**Cardiovascular Disorders:**	☑	**Cardiovascular Disorders:**
	High Blood Pressure		Ankle or Feet Swelling
	Heart Disease/Heart Attack		Chest Pain
	Low Blood Pressure		Blood Clot
	High Cholesterol		Stroke
	High Triglycerides		Varicose Veins
	Congestive Heart Failure		

Digestive Tract-Please check all that apply

☑	**Digestive Tract:**	☑	**Digestive Tract:**
	Abdominal Pain		Flatulence
	Belching		Hemorrhoids
	Bloated Feeling		IBS (Irritable Bowl Syndrome)
	Celiac Disease		Nausea/Vomiting
	Colitis		Rectal Bleeding/ Itching
	Constipation		Ulcers
	Crohn's Disease		GERD/Acid Reflux
	Diarrhea		

Ears-Please check all that apply

☑	**Ears:**	☑	**Ears:**
	Draining from Ear		Itching Ears
	Earaches, Ear Infections		Ringing in Ears, Hearing Loss

Eyes-Please check all that apply

☑	**Eyes:**	☑	**Eyes:**
	Bags or Dark Circles under Eyes		Swollen, Reddened, or Sticky Eyelids
	Blurred or Tunnel Vision		Watery/Itchy Eyes

Females Only-Please check all that apply

☑	**Females:**	☑	**Females:**
	Abnormal Bleeding		Infertility
	Abnormal Discharge		Miscarriage
	Abnormal Pap Smear		Night Sweats
	Breast Lump(s)		Painful Intercourse
	Extreme Menstrual Pain		PMS
	Hot Flashes		

Patient Name_____ Date_____

Genitourinary-Please check all that apply

☑	**Genitourinary:**	☑	**Genitourinary:**
	Difficulty Urinating		Lack of Bladder Control
	Enlarged Prostate		Painful Urination
	Frequent Urination		Recurrent Urinary Infections
	Kidney Stones		

Liver and Gallbladder Disorders-Please check all that apply

☑	**Liver and Gallbladder Disorders**:	☑	**Liver and Gallbladder Disorders**:
	Cholecystectomy (Gall Bladder Removal)		Non-Alcoholic Fatty Liver Disease
	Cirrhosis		Primary Biliary Cirrhosis
	Gall Stones		Right Scapula Pain (Shoulder blade)
	Hepatitis		Upper Right Quadrant Pain Below Right Rib Cage
	Light Colored Stool		

Males Only-Please check all that apply

☑	**Males Only:**	☑	**Males Only:**
	Breast Lump		Erection Difficulties
	Enlarged Prostate		Low Testosterone

Musculoskeletal-Please check all that apply

☑	**Musculoskeletal:**	☑	**Musculoskeletal:**
	Joint Pain		Muscle Soreness
	Arthritis		Osteoporosis/Osteopenia
	Bone Fractures		Stiffness or Limitation of Movement
	Low Back Pain		Vertebral Disc problem

Neurological-Please check all that apply

☑	**Neurological:**	☑	**Neurological:**
	Aggressiveness, Anger, Irritability		Insomnia
	Alzheimer's Disease		Mood Swings
	Anxiety, Fear, Nervousness		Parkinson's
	Depression		Seizures, Epilepsy
	Dizziness		Tremors

Patient Name_____ Date_____

Nails-Please check all that apply

☑	**Nails:**	☑	**Nails:**
	Absence of Lunula (Half shaped moon at bottom of nail)		Separation of nail plate from the underlying nail bed
	Clubbing		Splinter Hemorrhage
	Fungus		Spoon Shaped
	Horizontal Ridges		Terry's Half (Proximal portion of nail is white and distal is dark)
	Longitudinal Brown Lines		Transverse White Lines (Mee's Lines)
	Longitudinal Ridges		Vertical Ridges
	Pitting		White Spots

Nail Color-Please Check all that apply

☐ Blue ☐ Black ☐ Yellow ☐ White ☐ Brown-Grey ☐ Pink or Red ☐ Green

Nose-Please check all that apply

☑	**Nose:**	☑	**Nose:**
	Excessive Mucous Formation		Sinus Problems
	Hay Fever		Sneezing Attacks
	Nose Bleeds		Stuffy Nose

Oral and Throat-Please check all that apply

☑	**Oral and Throat:**	☑	**Oral and Throat:**
	Bad Breath		Cold Sores
	Bleeding Gums		Periodontal Disease
	Calculus (tarter) on Teeth		TMJ/Teeth Grinding
	Coating (white) on Back of Tongue		

Respiratory-Please check all that apply

☑	**Respiratory:**	☑	**Respiratory:**
	Asthma		History of Pneumonia
	Chest Congestion		Shortness of Breath
	Chronic Bronchitis		Sleep Apnea
	Difficulty Breathing		Snoring
	Emphysema		

Skin-Please check all that apply

☑	**Skin:**	☑	**Skin:**
	Acne		Excessive Hair Growth
	Bruises Easily		Hair Loss
	Chronic Rashes		Hives
	Dry Skin		Infection (Boils, Ulcers, etc.)

*Patient Name*_____ *Date*_____