First Name_____ **Last Name** _____ **Preferred Name**_____

Address _____ **Referred By** _____

City _____ **Telephone Numbers: Home** _____

Postal Code _____ **Date of Birth:** _____ **Mobile** _____

Email Address _____ **Work** _____

Emergency Contact Name _____ **Emergency Contact Number** _____

Occupation _____ **Employer** _____

Are you being treated for any medical conditions at the present or have you been within the last year?
Yes ☐ No ☐ Not Sure ☐

If so, why? _____

When was your last medical checkup? _____

Has there been any changes to your general health in the last year? Yes ☐ No ☐ Not Sure ☐

If yes, please explain: _____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
Yes ☐ No ☐ Not Sure ☐

If yes, please list:_____ (List attached ☐)

_____

_____

Do you have any allergies? Yes ☐ No ☐ Not Sure ☐

If yes, please list in the following categories below:

Medications: _____

Latex/Rubber Products _____

Other (e.g. Hayfever, Foods) _____

Have you ever had a peculiar or adverse reaction to any medications or injections?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain: _____

Do you have, or have you ever had asthma? Yes ☐ No ☐ Not Sure ☐

If so, type of puffer: _____

Do you have, or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Yes ☐ No ☐ Not Sure ☐

Have you ever had hepatitis, jaundice or liver disease? Yes ☐ No ☐ Not Sure ☐

If yes, which type of hepatitis? _____

Do you have a prosthetic or artificial joint? Yes ☐ No ☐ Not Sure ☐

If yes, please explain: _____

Do you have, or have you had a bleeding problem or bleeding disorder? Yes ☐ No ☐ Not Sure ☐

If so, please explain: _____

Have you been hospitalized for any illness or operations in the last 5 years? Yes ☐ No ☐ Not Sure ☐

If yes, please explain: _____

Do you have any conditions/therapies that could affect your immune system, e.g. leukemia, AIDS, HIV, radiotherapy, chemotherapy or are you on an immunosuppressant? Yes ☐ No ☐ Not Sure ☐

If yes, please explain: _____

Do you have any of the following? Please circle all that apply

Alzheimer's	Kidney Disease	Drug/Alcohol Dependency	STDs
Angina/Chest Pain	Lung Disease	Steroid Therapy	Shortness of Breath
Anemia	Epilepsy or Seizures	Lupus	Stomach Ulcers
Arthritis	Fibromyalgia	Migraines	Stroke
Blood Transfusion	Head/Neck Injury	Hypo/Hyperglycemia	Thrush
Cancer	Heart Attack	Osteoporosis Medication	Thyroid Disorder
TMJ Disorder	Cold Sores	High/Low Blood Pressure	Parkinson's Disease
Tuberculosis	Hodgkin's Disease	Rheumatic Fever	Diabetes

Are there any other conditions or diseases not listed above that you have or have had?

Yes ☐ No ☐ Not Sure ☐

If yes, please list: _____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, heart disease) Yes ☐ No ☐ Not Sure ☐

If yes, please explain: _____

Do you smoke or use chew tobacco products? Yes ☐ No ☐ Not Sure ☐

Are you Pregnant? Yes ☐ No ☐ Not Sure ☐

What is your preferred method of contact? Please circle Phone Email Mail

The information I have given above is true to the best of my knowledge

Patient Signature _____ Date _____