

Medical History Form - Body Systems

Do you have these or any other Skeletal /Muscular or Skin issues?

Artificial Joints *

Yes No

Rheumatism *

Yes No

Tumors *

Yes No

Add Unlisted Dermal, Muscular, Skeletal Items Here

Enter the item not listed here



Do you have these or any other Organ (Lungs, Kidney, Liver, Stomach, etc) issues?

Jaundice *

Yes No

Sinus Problems *

Yes No

Kidney Disease *

Yes No

Stomach Problems *

Yes No

Liver Disease *

Yes No

Ulcers *

Yes No

Add Unlisted Organs (Liver, GI, Lungs, Kidneys, Reproductive) Items Here

Enter the item not listed here



Do you have these or any other Cardiovascular Issues (Heart, Blood flow, Veins, Arteries, etc)?

Blood Disease *

Yes No

Heart Murmur *

Yes No

Excessive Bleeding *

Yes No

Pacemaker *

Yes No

Heart Disease *

Respiratory Problems *

Yes No

Yes No

Add Unlisted Cardiovascular, Circulatory Items Here

Enter the item not listed here



Do you have these or any other Neural Issues (Brain, Spine, Nerves, etc)?

Dizziness *

Yes No

Head Injuries *

Yes No

Epilepsy *

Yes No

Nervous Disorders *

Yes No

Add Unlisted Nervous System Items Here

Enter the item not listed here



Are you allergic to these or any other substances (Medications, Materials, Food, etc)?

Allergies *

Yes No

Allergy - Other *

Yes No

Allergy - Aspirin *

Yes No

Allergy - Penicillin *

Yes No

Allergy - Codeine *

Yes No

Allergy - Sulfa *

Yes No

Allergy - Erythro *

Yes No

Aspirin Allergy *

Yes No

Allergy - Hay Fever *

Yes No

Penicillin *

Yes No

Add Unlisted Allergies Items Here

What else are you allergic to:

Enter the item not listed here



I have disclosed all my allergies. *

Do you have any other conditions we should know about?

Allergy - Latex *

Yes No

Fainting *

Yes No

HIV *

Yes No

Mental Disorders *

Yes No

Other *

Yes No

Pregnancy *

Yes No

Radiation Treatment *

Yes No

Rheumatic Fever *

Yes No

Venereal Disease *

Yes No

Add Unlisted Other Items Here

Enter the item not listed here



Are you taking these or any other Medications?

*Pre-Med - Amox *

Yes No

*Pre-Med - Clind *

Yes No

*Pre-Med - Other *

Yes No

Add Unlisted Medications Items Here

I have disclosed all medications I currently take. *

Additional Questions

Additional Questions

Are you currently under the care of a physician? *

Yes No

Are you on a special diet? *

Yes No

Have you had any serious neck or head injuries? *

Yes No

Do you experience any pain in your teeth? *

Yes No

Do you experience any tooth sensitivity? *

Yes No

Do you grind your teeth? *

Yes No

Do you suffer from TMJ? *

Yes No

Do you use controlled substances? *

Yes No

Do you use tobacco? If so, how frequently? *

Yes No

Taking any oral contraceptives? *

Yes No

Do you have any other health issues or concerns that were not listed? *

Yes No

Do you snore at night? *

Yes No

Has someone else told you that you snore at night? *

Yes No

Do you wake up feeling tired and unrefreshed? *

Yes No

Are you often tired throughout the day? *

Yes No

Do you have trouble breathing through your nose? *

Yes No

Do you have any past nasal surgeries? *

Yes No

Have you ever been diagnosed with sleep apnea? *

Yes No

Have you ever been recommended to try CPAP by a doctor? *

Yes No

Have you ever woken up at night because you felt like you couldn't breathe well? *

Yes No

Patient's First Name *

Patient's Last Name *

Sign Here

Signature *



Date *

01/08/2025

