

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 D.O.B: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Email: \_\_\_\_\_

### Confidential Medical History

Name of Family Doctor & Phone #: \_\_\_\_\_

Is there family history of Diabetes and/or Heart Disease: YES NO

Explain: \_\_\_\_\_

Are you taking any medication: YES NO

Explain: \_\_\_\_\_

Are you allergic to any medication? YES NO

Explain: \_\_\_\_\_

Do you bruise easily or have prolonged bleeding? YES NO

Do you experience shortness of breath or chest pain? YES NO

Have you ever had an injury to your Head, Face or Mouth YES NO

Have you had major surgery? YES NO

Explain: \_\_\_\_\_

Are you Pregnant? YES NO

Have you ever **tested positive** for Hepatitis? YES NO

Have you ever **tested positive** for HIV? YES NO

Have you ever noticed bad breath or bad taste in your mouth? YES NO

Would you like you smile to be whiter? YES NO

Do you snore? YES NO

***Have you ever been treated for:***

Rheumatic Fever	YES	NO	Lung Disease	YES	NO
Heart Murmur	YES	NO	Heart Disease	YES	NO
Tuberculosis	YES	NO	Gall Bladder	YES	NO
Heart Attack	YES	NO	Stroke	YES	NO
Liver or Kidney Disease	YES	NO	Cancer	YES	NO
Joint Replacement	YES	NO	Jaundice	YES	NO
Scarlet Fever	YES	NO	Diabetes	YES	NO
Pacemaker	YES	NO	Epilepsy	YES	NO
High Blood Pressure	YES	NO	Diphtheria	YES	NO

Other: \_\_\_\_\_

The above information is complete to the best of my knowledge and I have not omitted any pertinent information.

Signature: \_\_\_\_\_