

## Medical History All information is confidential

Patient's Name:					Date of Birth:							
List all medications you are cur	rent	lv tal	king ind	cludin	าย ท	on-prescri	otioi	ı drı	gs, vitamins and herbs: (I	f vou h	nave a	
ist with you, we will be glad to copy		•	_		-	-	-			-		
Are you allergic to any medicat	ions	? If s	so, plea	se list	t the	em here:						
						_ Are you	alleı	rgic	to latex? (Please circle)	YES	NO	
Physician's Name and Phone #:	:											
•										D.C.	NIC	
Are you required to take an anti	ıbıot	1c (p	re-med	icatio	n) t	before havi	ng c	lenta	il treatment? (Circle) Y	LS	N(	
Do you have now or have a hi	stor	v of	any of	the fo	ollo	wing (plea	ise n	narl	k each item either ves or	no. E	00	
•		<i>y</i> 01	uiij oi		0110	Wing (prec	.50 1		i cuem item citiler yes or	110, 1		
NOT LEAVE ANY BLANK):	:											
	Y	N					Y	N		Y	N	
ADD/ ADHD			Excessive Bleeding						Psychiatric Treatment			
Aids/ HIV			Frequent Headaches						Recreational Drug Use			
/ 1103/ 111 V			Gastrointestinal Issues									
Alcoholism			Gastroii	ntestin		sues			Rheumatic Fever			
					al Is	sues 'impaired			Rheumatic Fever Ringing in Ears			
Alcoholism				diffic	al Is							
Alcoholism Allergies/ Hives			Hearing	diffic disease	al Is				Ringing in Ears			
Alcoholism Allergies/ Hives Anemia			Hearing Heart D Heart M	diffic isease Iurmur	al Is ulty/				Ringing in Ears Sinus Problems			
Alcoholism Allergies/ Hives Anemia Arthritis Asperger Syndrome/ Autism			Hearing Heart D Heart M Hepatiti	diffici isease Iurmur s (Circ	al Is	A B C )			Ringing in Ears Sinus Problems Stroke			
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Patient/Guardian Signature \_\_\_\_\_\_ Date \_\_\_\_\_