210 N. Custer Rd. Suite 150
McKinney, Tx 75071
972-540-0605

Medical History

Patient name_____ Birth Date_____

Date and purpose of most recent medical examination_____

Name of physician_____ phone_____

Are you presently under medical care_____ Reason_____

Medications you are now taking_____

Do you use tobacco_____

Have you ever had radiation treatment for cancer? _____

Vitamin/Mineral supplements you are now taking_____

WOMEN: Are you pregnant? _____ Month_____ Nursing_____

Reason for today's visit_____

When was your last dental exam/Xrays? _____ dental cleaning? _____

Allergies: medications: _____

Other allergies_____

Please check any of the following which you had or have been treated for:

◯ Heart Attack	◯ Heart Murmur	◯ Heart Surgery/Pacemaker
◯ Angina/Chest Pain	◯ Irregular Heart Beat	◯ Tachycardia (Racing Heartbeat)
◯ Rheumatic Fever	◯ Stroke	◯ Cancer
◯ Bleeding problem	◯ Circulatory problem	◯ High Blood Pressure

◯ Low Blood Pressure	◯ Diabetes	◯ Hypoglycemia
◯ Arthritis	◯ Ulcers	◯ Kidney Infection/Failure
◯ Hepatitis /Jaundice	◯ Hypo/Hyperthyroid	◯ Tuberculosis
◯ Emphysema	◯ Adrenal Disease	◯ Venereal Disease
◯ Epilepsy/Seizures/Convulsions	◯ Psychiatric Treatment	◯ Artificial Joint
◯ Artificial heart Valve	◯ Leukemia	◯ Hodgkin's Disease
◯ Gum Disease/Bleeding	◯ Periodontal Disease	◯ Bad Breath
◯ Sensitivity To Cold	◯ Sensitivity To Hot	◯ Sensitivity When Biting
◯ How Often Do You	Brush?_____	Floss?_____
◯ Metallic Taste	◯ Increased Salivation	◯ Burning Sensation In Mouth
◯ Tremor	◯ Numbness/Tingling Sensation	◯ Leg Cramps
◯ Joint Pains	◯ Ringing Noises In Ears	◯ Chronic fatigue
◯ Low Body Temperature	◯ Skin Rash	◯ Acne
◯ Nausea/Vomiting	◯ Edema	◯ Restricted/Dim Vision
◯ Sensitivity To Light	◯ Speech Disorders	◯ Abdominal Cramps
◯ Colitis/Diverticulitis	◯ Frequent Constipation	◯ Persistent Diarrhea
◯ Irritability	◯ Nervousness	◯ Anxiety
◯ Depression	◯ Apathy	◯ Inability To Concentrate
◯ Loss of memory	◯ Fits Of Anger	◯ Insomnia
◯ Suicidal Tendencies	◯ Anorexia (Poor Appetite)	◯ Cold Hands And Feet
◯ Frequent Urination	◯ Excessive Perspiration	◯ Swollen Lymp Nodes
◯ Breathing Difficulty	◯ Persistent Cough	◯ Chronic Sinus Congestion
◯ Hay Fever/Asthma	◯ Glaucoma	◯ Shingles
◯ Bell's Palsy	◯ PMS	◯ Multiple sclerosis
◯ Lupus Erythematous	◯ Headaches	◯ Migraines

◯ Dizziness	◯ Face Pain	◯ Tooth Pain

◯ Difficulty Opening	◯ Pain On Jaw Movement	◯ Ringing In The Ears
◯ Grinding Teeth	◯ Chronic Neck Pain	◯ Chronic Backache
◯ Brain Fog	◯ Post Nasal Drip	◯ Sugar Cravings
◯ Irritable Bowel Syndrome	◯ Dark Circles Under Eyes	◯ Disturbed Sleep
◯ Night Sweats	◯ Muscle Cramps	◯ Prostate Problems
◯ Rectal Itching	◯ Pain In The Navel Region	◯ Bed Wetting
◯ Pain Down The Arms Into The Fingers		

Other serious illnesses or major surgery_____

Signature(patient/parent/guardian) _____ Date_____