

- I. Cholesterol reducing drugs?..... Yes No
- J. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain Relievers?..... Yes No
- K. Weight reduction pills or diet aids (over the counter or "natural" products)?..... Yes No
- L. Vitamins, Natural remedies (ginko biloba, ephedra, ginseng, etc.) or other supplements?.... Yes No
- M. Marijuana, cocaine or other "recreational" drugs?..... Yes No
- N. Any other regular medications, pills, supplements or drugs?..... Yes No

PLEASE LIST ALL CURRENT MEDICATIONS HERE: _____

10. ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

- A. Local anesthetic (Novocain-like drugs)?..... Yes No
- B. Penicillin, Amoxicillin, Cephalosporins?..... Yes No
- C. Other antibiotics?..... Yes No
- D. Barbiturates, sedatives?..... Yes No
- E. Aspirin, ibuprofen, NSAIDS, or other pain medicines?..... Yes No
- F. Codeine or other narcotics or opioids?..... Yes No
- G. Latex?..... Yes No
- H. Other allergies or reactions?..... Yes No

Please list: _____

- 11. Do you have hay fever, frequent skin rashes, etc?..... Yes No
- 12. Do you use alcohol? How much per day? _____ Yes No
- 13. Do you smoke?..... Yes No
 What product and how much per day? _____ For how long? _____
- 14. Do you use spit tobacco?..... For how long? _____
- 15. Are you or have you been, in a drug or alcohol recovery program?..... Yes No
- 16. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?..... Yes No
- 17. Do you wish to talk to the doctor privately about anything?..... Yes No
- 18. Any additional comment? _____

19. WOMEN

- A. Are you taking birth control pills?..... Yes No
- B. Are you pregnant, trying to become pregnant or any chance you might be pregnant?..... Yes No
- C. Are you BREAST FEEDING?..... Yes No
- D. Are you taking hormonal replacement?..... Yes No

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____ Date _____ Signature of person completing Health History _____ Doctor's Initials

THANK YOU. Please return this form to the receptionist before completing others in this packet; do not write below this line.

Medical Update: I have reviewed my health history dated _____ and confirm that it accurately states past and present conditions.

Exceptions: _____

_____ Date _____ Signature of person completing Health Update _____ Doctor's Initials