Medical History

Please fill out to the best of your knowledge.

Have you had any major illnesses or surgeries that resulted in you being hospitalized within the last six months? If yes. List dates and reasons for hospitalization.

________________________________ ☐ Yes | ☐ No

Are you currently taking any medications? If yes, list medications and reason for taking.

________________________________ ☐ Yes | ☐ No

Have you had or currently have any of the following conditions?

Allergies ☐ Yes | ☐ No

List: ________________________________

Asthma ☐ Yes | ☐ No

Arthritis ☐ Yes | ☐ No

Anemia or other Blood Disorder ☐ Yes | ☐ No

Breathing Problems ☐ Yes | ☐ No

Heart Attack ☐ Yes | ☐ No

Date(s): ________________________________

High Blood Pressure ☐ Yes | ☐ No

Stroke ☐ Yes | ☐ No

Date(s): ________________________________

Pacemaker ☐ Yes | ☐ No

Date of placement: ________________________

Radiation Therapy ☐ Yes | ☐ No

Epilepsy / Seizures ☐ Yes | ☐ No

Pregnant / Nursing ☐ Yes | ☐ No

Head / Neck / Back Injury ☐ Yes | ☐ No

Please list any other pertinent health information you wish to make the course administrators aware of:

____

Patient Name: DOB:

Dental History

Have you ever had any dental surgeries? If yes, list.

________________________________ ☐ Yes | ☐ No

Do you currently have decay or restorative needs?

☐ Yes | ☐ No

How long has it been since your last dental cleaning?

____

Are you missing any teeth?

☐ Yes | ☐ No

How long has it been since your last dental x-rays?

____

Emergency Contact

Name: ________________________________

Phone: ______________________

Relation: ____________________

Medical Doctor Contact

Name: ________________________________

Phone: ______________________

Address: ______________________________