MAGNA PATIENT HEALTH HISTORY

(REVISED 2/14/2023)

TODAY'S DATE:____________________

PATIENT'S NAME:____DATE OF BIRTH:__________

CURRENT MEDICATIONS:____

____

____

____

PLEASE CIRCLE ALL THAT APPLY (PAST AND PRESENT):

ADHD
AUTISM
ANXIETY
DEPRESSION
DEMENTIA
ALZHEIMERS
EPILEPSY
SEIZURES
FAINTING
HEAD/NECK/SPINE INJURY
HEADACHES/MIGRAINES

CANCER
RADIATION
CHEMOTHERAPY
TUMORS

PREGNANT
IF YES, DUE DATE:______

HEART MURMUR
ARTIFICIAL HEART VALVE
PACEMAKER
HEART DISEASE
KIDNEY DISEASE
LIVER DISEASE
RHEUMATIC FEVER
STROKE
HIGH BLOOD PRESSURE
ARTIFICIAL JOINTS

JAUNDICE
RHEUMATISM
BLOOD DISEASE
EXCESSIVE BLEEDING
HEPATITIS
HIV
TUBERCULOSIS

DIABETES
ULCERS
REFLUX
THYROID PROBLEMS
SINUS PROBLEMS

RESPIRATORY PROBLEMS
COPD
OXYGEN TANK
COVID-19
TOBACCO USE

GRINDING TEETH
CLENCHING
JAW CLICKING
CHEWING ISSUES
JAW LOCKING
BRACES/ORTHODONTIST CARE
TOOTH EXTRACTION ISSUES

DRUG ALLERGY (_________________________)
ARTIFICIAL FLAVOR ALLERGY (______________)
FOOD ALLERGY (_________________________)
OTHER ALLERGY (_________________________)

COLOR ALLERGY
LATEX ALLERGY
TREE NUT ALLERGY

ANY OTHER MEDICAL INFORMATION:____

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I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS AND ACCURATELY ANSWERED TO THE BEST OF MY KNOWLEDGE. PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH

PATIENT/POA/GUARDIAN SIGNATURE:____

RELATIONSHIP TO PATIENT (IF APPLICABLE):_________________ DATE:________________

EMERGENCY CONTACT NAME:____

RELATIONSHP:________________________ PHONE NUMBER(S):_____________________