 Medical History

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Are you under a physician’s care now? **Y**/**N\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you ever had a serious head or neck injury? **Y**/**N\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you ever been hospitalized or had a major operation? **Y**/**N\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Are you taking any medications, pills, or drugs? **Y**/**N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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* Do you take, or have you taken, Phen-Fen or Redux? **Y**/**N\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you ever taken Fosamax, Boniva, Actonel,

or any other medications containing biphosphates? **Y**/**N\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Are you on a special diet? **Y**/**N\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you use controlled substances? **Y**/**N** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women:**

* Pregnant/ Trying to become pregnant? **Y**/**N\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Nursing? **Y**/**N** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Taking oral contraceptives? **Y**/**N** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:**

* Acrylic  **Y**/**N**
* Aspirin **Y**/**N**
* Codeine  **Y**/**N**
* Latex **Y**/**N**
* Local Anesthetics **Y**/**N**
* Metal **Y**/**N**
* Sulfa Drugs **Y**/**N**
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle any current or past conditions you have had:**

* AIDS/HIV positive
* Alzheimer’s Disease
* Anaphylaxis
* Anemia
* Angina
* Arthurites/Gout
* Artificial Heart Valve
* Artificial Joint
* Asthma
* Blood Disease
* Blood Transfusion
* Breathing Problems
* Bruise Easily
* Cancer
* Chemotherapy
* Chest Pains
* Cold Sores
* Congenital Heart Disease
* Convulsions
* Cortisone Medicine
* Diabetes
* Drug Addiction
* Easily Winded
* Emphysema
* Epilepsy/ Seizures
* Excessive Bleeding
* Excessive Thirst
* Fainting/ Dizziness
* Frequent Cough
* Frequent Diarrhea
* Frequent Headaches
* Genital Herpes
* Glaucoma
* Hay Fever
* Heart Attack/ Failure
* Heart Murmur
* Heart Pacemaker
* Heart Trouble
* Hemophilia
* Hepatitis A, B or C
* Herpes
* High Blood Pressure
* High Cholesterol
* Hives or Rash
* Hypoglycemia
* Irregular Heartbeat
* Kidney Problems
* Leukemia
* Liver Disease
* Low Blood Pressure
* Lung Disease
* Mitral Valve Prolapse
* Osteoporosis
* Pain in Jaw Joints
* Parathyroid Disease
* Psychiatric Care
* Radiation Treatments
* Recent Weight Loss
* Renal Dialysis
* Rheumatic Fever
* Rheumatism
* Scarlet Fever
* Shingles
* Sickle Cell Disease
* Stroke
* Swelling Limbs
* Thyroid Disease
* Tonsilitis
* Tuberculosis
* Tumors/ Growths
* Ulcers
* Venereal Disease

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_