MEDICAL HISTORY

Today's Date_____

NAME_____ Birthdate_____

Physician name_____ Physician phone_____

Are you in general good health at this time?	Yes	No
Are you under any medical treatment at this time?	Yes	No
Are you taking any medications? Prescription and over the counter	Yes	No

If yes, please list_____

_____

_____

Have you ever had a reaction to any medication?	Yes	No
If yes, to what? _____		
Have you been hospitalized in the last 5 years?	Yes	No
If yes, for what?_____		
Are you allergic to penicillin? Latex? Any other medication?	Yes	No
If yes, please list_____		

Have you ever had or do you now have:

heart disease	yes	no	depression	yes	no
cardiovascular disease	yes	no	diabetes	yes	no
pacemaker/defibrillator	yes	no	kidney disease	yes	no
mitral valve prolapse	yes	no	hepatitis	yes	no
blood thinners	yes	no	tuberculosis	yes	no
stroke	yes	no	asthma/hay fever	yes	no
respiratory disease	yes	no	sinus trouble	yes	no
artificial joints(premedicate?)	yes	no	ulcers	yes	no
arthritis	yes	no	venereal disease	yes	no
cancer	yes	no	HIV positive	yes	no
chemotherapy	yes	no	AIDS	yes	no
radiation therapy	yes	no	thyroid problems	yes	no
blood transfusion	yes	no	seizures	yes	no

Do you suffer from excessive bleeding/bruising?	Yes	No
Do you experience dizzy/fainting spells?	Yes	No
Have you been diagnosed with osteoporosis or osteopenia?	Yes	No
Do you take or have you ever taken bisphosphonates?	Yes	No
(Bisphosphonates include, but may not be limited to Aredia, Zometa, Boniva, Actonel, Fosamax)		
WOMEN: Are you taking birth control pills?	Yes	No
Are you pregnant? Due Date_____	Yes	No

Do you suffer from any other medical condition that we should be aware of?	Yes	No
If yes, please explain_____		

I believe the above information to be true. Should further information be needed, permission is granted to contact my physician. I will notify this office of any changes in my health status.

Signature_____ Date_____