MEDICAL HISTORY

Date: ___/___/_____

Name: _____ Birth Date: ___/___/_____
Physician's Name: _____ Phone: _____
Pharmacy: _____ Phone: _____

Drug Allergies:

____ Aspirin
____ Codeine
____ Latex
____ Penicillin
____ Sulfa
____ Other: _____

Have you ever had any of the following (check if applicable)?

___ Alcohol Abuse
___ Allergies
___ Allergies to Anesthetics
___ Arthritis
___ Artificial Heart Valves
___ Artificial Replacement (Joint/Etc.) Type: _____
___ Asthma
___ Back Problems
___ Blood Disease
___ Blood Thinners
___ Cancer-type: _____
___ Circulatory Problems
___ COPD
___ Diabetes
___ Drug Abuse
___ Emphysema
___ Epilepsy
___ Frequent/Severe Headaches
___ Heart Attack
___ Heart Murmur
___ Other Heart Problems _____
___ Hemophilia
___ Hepatitis A
___ Hepatitis B
___ Hepatitis C
___ High Blood Pressure
___ HIV/AIDS
___ Jaundice
___ Liver Disease
___ Low Blood Pressure
___ Osteoporosis
___ Psychiatric Care
___ Radiation Treatment
___ Recent Weight Loss/Gain
___ Rheumatic Fever
___ Sinus Problems
___ Stroke
___ Swollen Neck Glands
___ Ulcer

List any Medication that you are currently taking:

_____

_____

Are you pregnant? ___yes ___no If yes, # of weeks _____

Do you smoke/use tobacco? ____yes _____no

Have you ever taken the diet pills Phen-fen or Redux? ____ yes ____no

Have you taken Actonel/Boniva/Fosamax or other Bisphosphonates for calcium deficiency? ____yes ____no

Is there any other information about your health that we should know? _____

The above information is true to the best of my knowledge.
RESPONSIBLE PARTY FOR PATIENT:

Name: _____Signature: _____