Medical History

Name: _____ **Date of Birth**: _____

Are you under Physician's care? Yes ⬭ No ⬭ If yes _____

Have you had a major operation? Yes ⬭ No ⬭ If yes _____

Any serious head or neck injury? _____

Are you taking medication? _____

Do you take, or ever taken, Phen-Fen or Redux? Yes ⬭ No ⬭ If yes _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? _____

Are you on a special diet? Yes ⬭ No ⬭ Do you use tobacco? Yes ⬭ No ⬭

Do you use controlled substances? Yes ⬭ No ⬭ If yes _____

Are you (check what applies): Pregnant/Trying? ⬭ Nursing? ⬭ Taking oral contraceptives? ⬭

Allergic to any of the following?: Aspirin ⬭ Penicillin ⬭ Codeine ⬭ Acrylic ⬭ Metal ⬭ Latex ⬭

Sulfa Drugs ⬭ Local Anesthetics ⬭ Other: _____

Do you have, or have you had, any of the following? (check all that apply):

____ AIDS/HIV	____ Cortisone Medication	____ Hemophilia	____ Radiation
____ Alzheimer's	____ Diabetes	____ Hepatitis A	___ Recent Weight Loss
____ Anaphylaxis	____ Drug Addiction	____ Hepatitis B or C	____ Renal Dialysis
____ Anemia	____ Easily Winded	____ Herpes	____Rheumatism
____ Angina	____ Emphysema	____ High Blood Pressure	____ Scarlet Fever
____ Arthritis/Gout	____ Epilepsy or Seizures	____ High Cholesterol	____ Shingles
____ Artificial Heart Valve	____ Excessive Bleeding	____ Hives or Rash	___ Sickle Cell Disease
____ Artificial Joint	____ Excessive Thirst	____ Hypoglycemia	____ Sinus Problem
____ Asthma	____ Fainting Spells/Dizziness	____ Irregular Heartbeat	____ Spina Bifida
____ Blood Disease	____ Frequent Cough	____ Kidney Problems	___ Stomach Disease
____ Blood Transfusion	____ Frequent Diarrhea	____ Leukemia	____ Stroke
____ Breathing Problems	____ Frequent Headaches	____ Liver Disease	___ Swelling of Limbs
____ Bruise Easily	____ Genital Herpes	____ Low Blood Pressure	___Thyroid Disease
____ Cancer	____ Glaucoma	____ Lung Disease	___ Tonsilitis
____ Chemotherapy	____ Hay Fever	____ Mitral Valve Prolapse	___ Tuberculosis
____ Chest Pains	____ Heart Attack/Failure	____ Osteoporosis	___ Tumors/Growths
____ Cold Sores/Fever Blisters	____ Heart Murmur	____ Pain in Jaw Joints	___ Ulcers
___ Congenital Heart Disorder	___ Heart Pacemaker	___ Parathyroid Disease	___ Venereal Disease
____ Convulsions	____ Heart Trouble/Disease	____ Psychiatric Care	___ Yellow Jaundice

Back

Any other diseases or serious illness not listed that you have ever had?

_____

Doctor Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

Doctor's notes or comments: