PATIENT MEDICAL HISTORY

Patient's Name______________________________ **Date**______________________

Physician's Name____________________ **Clinic Name** ______________ **Phone**______________

Date of Last Medical Examination____

1. **Are you under medical treatment now?** Yes No
   If yes, what is the condition? ______________________________________

2. **Have you ever been hospitalized for any surgical operations or serious illness?** Yes No
   If yes, please explain______________________________________

3. **Have you ever had excessive bleeding following an injury?** Yes No

4. **Do you smoke or use tobacco products?** Yes No
   If yes, how often? ____________________

5. **Are you allergic to or have you had any reaction to the following:**

Local Anesthetic (Novocaine)	Yes	No
Penicillin or Other Antibiotics	Yes	No
Sulfa Drugs	Yes	No
Sedatives	Yes	No
Iodine	Yes	No
Aspirin	Yes	No
Codeine	Yes	No

Other (please identify)______________________

6. **Women Only**
   a) Are you pregnant or think you may be pregnant? Yes No
   b) Are you nursing? Yes No
   c) Are you taking contraceptives? Yes No

7. **Check any of the following which you have had or have at present**:

____AIDS or HIV Infection
____Anemia
____Angina
____Artificial Heart Valve
____Artificial Joints (knee, hip*)
____Asthma
____Auto-immune Disease
____Blood Transfusion (Date :_________)
____Bulimia
____Cancer (Specify :____________)
____Cataracts
____Chemical Dependency
____Chronic Fatigue Syndrome
____Convulsions
____Depression/Anxiety
____Diabetes (Type: __________)
____Dieting Concerns
____Dizziness
____Epilepsy
____Fainting
____Hay Fever
____Headaches
____Heart Attack (Date :________)
____Heart Disease
____Heart Murmur*
____Hemophilia (Bleeding Disorder)
____Hepatitis A (Infectious)
____Hepatitis B (Serum)
____Hepatitis C
____High / Low Blood Pressure (circle)
____Kidney Disease
____Liver Disease
____Lupus
____Pacemaker / Defibrillator
____Psychiatric Care
____Rheumatic Fever/Scarlet Fever (Date :______________)
____Sickle Cell Anemia
____Sinus Infections
____Stroke (Date :__________)
____Thyroid Disorder
____Tuberculosis
____Ulcer (Specify :________)
____Venereal Disease
____ **None Apply**

8. **Check any over the counter Herbal or Natural Supplements you are taking:**

____Appetite Suppressants
____Aspirin
____Diet Supplements
____Garlic
____Ginkgo Biloba
____Ginseng
____Motrin/Advil (Ibuprophen)
____St. Johns Wort
Other (Please Specify)

9. **Are you taking or have you ever taken Bisphosphonates for osteoporosis & cancer such as:**

_____Fosamax
_____ Boniva
_____ Actonel
_____ Zometa
_____ Other
_____ Aredia
_____Ostac
_____ Skelid
_____ Didronel

***Is Pre-medication Necessary?** Yes No If Yes, why? ______________________________

Please List Any Other Medical Information______________________________

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Patient Name ____ **Date** ________________________________

Please List Any Medications, Including "Over The Counter", You Are Currently Taking:

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Patient Signature ____ **Date** ________________________________

** Below For Office Staff Only ***

DATE	SIGNATURE	CHANGE IN HEALTH OR MEDICATION