

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:

<input type="checkbox"/> AIDS or HIV Infection	<input type="checkbox"/> Diabetes (Type: _____)	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Dieting Concerns	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Angina	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Lupus
<input type="checkbox"/> Artificial Joints (knee, hip*)	<input type="checkbox"/> Fainting	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Rheumatic Fever/Scarlet Fever (Date : _____)
<input type="checkbox"/> Auto-immune Disease	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Blood Transfusion (Date : _____)	<input type="checkbox"/> Heart Attack (Date : _____)	<input type="checkbox"/> Sinus Infections
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke (Date : _____)
<input type="checkbox"/> Cancer (Specify : _____)	<input type="checkbox"/> Heart Murmur*	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hemophilia (Bleeding Disorder)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Hepatitis A (Infectious)	<input type="checkbox"/> Ulcer (Specify : _____)
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Hepatitis B (Serum)	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> None Apply
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> High Blood Pressure	

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

<input type="checkbox"/> Appetite Suppressants	<input type="checkbox"/> Ginkgo Biloba
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Ginseng
<input type="checkbox"/> Diet Supplements	<input type="checkbox"/> Motrin/Advil (Ibuprophen)
<input type="checkbox"/> Garlic	<input type="checkbox"/> St. Johns Wort
Other (Please Specify)	

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

<input type="checkbox"/> Fosamax	<input type="checkbox"/> Aredia
<input type="checkbox"/> Boniva	<input type="checkbox"/> Ostac
<input type="checkbox"/> Actonel	<input type="checkbox"/> Skelid
<input type="checkbox"/> Zometa	<input type="checkbox"/> Didronel
<input type="checkbox"/> Other	

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

Please List Any Other Medical Information _____

Patient Signature _____ Date _____

