Medical History

Patient Name:_____ **Date:**_____

Physician's name:_____ **Date of last exam**:_____

Have you ever been hospitalized or had a major operation? O Yes O No **Please list, including date:**

_____

Have you had a serious head or neck injury? O Yes O No
Please list any medication or pills you are taking and specify the reason for it (let us know if extra space needed:

_____

_____

Do you, or have you ever taken, Phen-Fen or Redux? (Dieting pills) O Yes O No
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? O Yes O No
Do you smoke? O Yes O No **If yes, how much?** _____
Do you use controlled substances? O Yes O No **If yes, how much/often?** _____

Women, are you: (Check all that apply)
Pregnant/Trying to get pregnant? □ Nursing? □ Taking oral contraceptives? □

Are you allergic to any of the following? (Check all that apply)
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Sulfa Drugs
□ Local Anesthetics □ Food: (Please Specify) _____ □ Other:_____

Please mark all that apply to you currently or has applied in the past:

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

__ **Mark here if none of the above.**

Emergency Contact: Name _____ Phone _____ Relationship_____

By signing below, I acknowledge that I have read and completed this form to the best of my knowledge and the above information is accurate at time of signing.

Signature: _____ **Date**: _____