# Medical History

First Name _____ Last Name _____

Have you ever had any of the following medical conditions?

| | | | | |
|---|---|---|---|---|
| ☐ Artificial Prosthes | ☐ Blood Thinner | ☐ Codeine Allergy | ☐ Heart Disease | ☐ Hepatitis |
| ☐ Latex Allergy | ☐ No Epi | ☐ Penicillin Allergy | ☐ Pre-Med | ☐ STD |
| ☐ Allegra | ☐ Allergies | ☐ Anemia | ☐ Arthritis | ☐ Artificial Joints |
| ☐ Asthma | ☐ Atenolol | ☐ Betapace | ☐ Blood Disease | ☐ Cancer |
| ☐ Clariton | ☐ Coumadin | ☐ Diabetes | ☐ Dizziness | ☐ Epilepsy |
| ☐ Excessive | ☐ Fainting | ☐ Flavix | ☐ Fosmix | ☐ Glaucoma |
| ☐ Growths | ☐ Head Injuries | ☐ Heart Murmur | ☐ High Blood Pressure | ☐ HIV |
| ☐ Bleeding | ☐ Hydrchlorothyazide | ☐ Hyperthyroid | ☐ Hyperthyroid | ☐ Hytrin |
| ☐ Jaundice | ☐ Kidney Disease | ☐ Lipitor | ☐ Liver Disease | ☐ Lopressor |
| ☐ Mental Disorders | ☐ Nervous Disorders | ☐ Pacemaker | ☐ Pregnancy | ☐ Radiation Treatment |
| ☐ Respiratory Problems | ☐ Rheumatic Fever | ☐ Rheumatism | ☐ Sinus Problems | ☐ Stomach Problems |
| ☐ Stroke | ☐ Tuberculosis | ☐ Tumors | ☐ Ulcers | ☐ Vasotec |
| ☐ Verapamil | ☐ Zantac | ☐ Cisapode | ☐ Zocor | ☐ HRT |

Do you have any other health problems?

- ☐ No
- ☐ Yes

Are you allergic to any of the following?

- ☐ Penicillin
- ☐ Tetracycline
- ☐ Sulfa drugs
- ☐ Sulfa drugs
- ☐ Codeine
- ☐ Latex
- ☐ Metals
- ☐ Dental
- ☐ Anesthetics
- ☐ Other allergies:

Are you taking any medications at this time?

- ☐ No
- ☐ Yes

Have you been admitted to a hospital in the last 2 years?

- ☐ No
- ☐ Yes

Are you under care of physician?

- ☐ No
- ☐ Yes

Do you use tobacco?

- ☐ No
- ☐ Yes

Do you use alcoholic beverages?

- ☐ No
- ☐ Yes

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

- ☐ No
- ☐ Yes

Have you ever taken diet drug such Fen-Phen?

- ☐ No
- ☐ Yes

Women: Are you pregnant?

- ☐ No
- ☐ Yes

Do you take birth control medications?

- ☐ No
- ☐ Yes

Women: Are you nursing?

- ☐ No
- ☐ Yes

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

_____ _____

Signature Date