



Patient Name: _____

Date of Birth: _____

Date: _____

MEDICAL HISTORY

Are you under a physician's care now? Yes No If Yes: _____

Have you ever been hospitalized or had a major operation? Yes No If Yes: _____

Have you ever had a serious head or neck injury? Yes No If Yes: _____

Are you taking any medications, pills, or drugs? Yes No If Yes: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If Yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If Yes: _____

Are you on a special diet? Yes No If Yes: _____

Do you use tobacco? Yes No If Yes: _____

Women: Are you... (mark what applies)

- Pregnant/ Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following? (mark what applies)

- Aspirin Penicillin Codeine Acrylic
- Metal Latex Sulfa Drugs Local Anesthetics

Do you have any other allergy? Yes No If Yes: _____

Do you use controlled substances? Yes No If Yes: _____

Do you have, or have you had, any of the following? Check any that apply

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

Other serious illness not listed above: _____

Medical History Comments: _____

Signature of Patient or Guardian

Date

Print Name

Relationship to Patient