Medical History

Patient Name _____ Date of Birth_____
Physician's Name_____ Physician's Phone _____
Has there been a change in your health in the past year? YES NO
If yes, explain _____
Have you been hospitalized or had a serious illness in the past 5 years? YES NO
If yes, explain _____

Please check next to YES or NO as it applies to you

YES	NO		YES	NO		YES	NO	
( )	( )	Heart Disease	( )	( )	Ulcers	( )	( )	Hemophilia
( )	( )	Heart Murmur	( )	( )	Asthma	( )	( )	Glaucoma
( )	( )	Irreg. Heart Beat	( )	( )	Anemia	( )	( )	Rheumatism
( )	( )	Chest Pain	( )	( )	Drug Abuse	( )	( )	Rheumatic Fever
( )	( )	Artificial Hrt Valve	( )	( )	Cold Sores	( )	( )	Hypoglycemia
( )	( )	Pace Maker	( )	( )	Hepatitis A	( )	( )	Fainting
( )	( )	High Blood Pressure	( )	( )	Hepatitis B	( )	( )	Alzheimer's
( )	( )	Low Blood Pressure	( )	( )	Jaundice	( )	( )	Transfusion
( )	( )	Mitral Valve Prolapse	( )	( )	Lung Disease	( )	( )	Stroke
( )	( )	Heart Surgery	( )	( )	Emphysema	( )	( )	Radiation
( )	( )	Positive TB Test	( )	( )	Tuberculosis	( )	( )	Epilepsy
( )	( )	HIV/Aids	( )	( )	Kidney Problems	( )	( )	Reflux
( )	( )	Venereal Disease	( )	( )	Dialysis	( )	( )	Arthritis
( )	( )	Fever Blisters	( )	( )	Leukemia	( )	( )	Pneumonia
( )	( )	Hives/Rash	( )	( )	Diabetes	( )	( )	Tobacco Use
( )	( )	Allergies	( )	( )	Liver Disease	( )	( )	Tumors
( )	( )	Cancer	( )	( )	Thyroid Problems	( )	( )	Bruise Easily

Are you allergic to Latex? YES NO
Please list any medications you are allergic to: _____
Please list your current medications and dosages:_____
_____
Women Please Check ( ) Pregnant ( ) Nursing ( ) Birth Control Pills ( ) Menopause
Have you had any other illness or condition not listed? YES NO
If yes, explain_____
Have you taken any Bisphosonates (Fosomax, Zometa, Aredia) in the past 10 years ?
_____

Patient or Guardian Signature_____ Date_____
Reviewed By _____Date_____