

MEDICAL HISTORY

Name of Physician _____

Date of last physical exam _____

Please indicate if you have ever had: Currently In the Past Never Had
 (Please mark the appropriate column)

Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If currently diabetic, are you insulin dependant? Y N			
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fen/Phen or other prescription weight loss drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack, Heart Surgery or Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker or Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any Prosthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

 If Currently, when/where were they placed? _____

Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

 If currently, have you ever been told that you should premedicate? Y N

Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (circle type) A B C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any Contagious diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV+ test result	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to any metals or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there any disease or condition not listed above that you have been diagnosed with? Y N

 If yes, please explain: _____

Have you had joint replacement within the last two years? Y N

 If yes, what type and when? _____

Are you pregnant or think you may be pregnant? Y N

 If yes, what is your due date? _____

Are you nursing? Y N

Are you taking any medications? (This includes prescription, over-the-counter, or herbal medicines) Y N

Please list all medications including dosage and frequency: _____

Are you taking any medications for the treatment of osteoporosis, bone pain or bone disease? Y N

Any allergies or adverse reactions to: (please circle) Penicillin Aspirin Sulfa Drugs Latex
 Local Anesthetic Other (Please list below)

Are you under a physician's care now? Y N

Please list any surgeries you have had: _____

Have you been hospitalized for any reason within the past five years? Y N

 If yes, please explain: _____

