

**MEDICAL HISTORY**

Name of Physician \_\_\_\_\_  
 Date of last physical exam \_\_\_\_\_

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

|  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
| 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 If Currently, when/where were they placed? _____       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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: \_\_\_\_\_

**Over Please**