Medical History

Name:____ **Date of Birth:**_________________________

Are you under a physician's care now?		Explain:
Have you ever been hospitalized or had major surgery?		If yes, what for?
Have you ever had serious head or neck injury?		When?
Are you taking any medications, pills or drugs?		List Meds:
Do you take, or have you taken, Phen-Fen or Redux?		When?
Have you ever taken Fosamax, Boniva, Actenol, or any other medications containing bisphosphonates?		If yes, when and for how long?
Are you on a special diet?		Explain:
Do you use tobacco?		How many daily?

Women: Are you?

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

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic	Metal
Latex	Sulfa Drugs	Local Anesthetics	Other:	

Do you use controlled substances? If yes,

AIDS/HIV Positive		Cortisone Medicine		Hemophilia		Radiation Treatment	
Alzheimer's Disease		Diabetes		Hepatitis A		Recent Weight Loss	
Anaphylaxis		Drug Addiction		Hepatitis B or C		Renal Dialysis	
Anemia		Easily Winded		Herpes		Rheumatic Fever	
Angina		Emphysema		High Blood Pressure		Rheumatism	
Arthritis/Gout		Epilepsy or Seizures		High Cholesterol		Scarlet Fever	
Artificial Heart Valve		Excessive Bleeding		Hives/Rash		Shingles	
Artificial Joint		Excessive Thirst		Hypoglycemia		Sickle Cell Disease	
Asthma		Fainting Spells/Dizziness		Irregular Heartbeat		Sinus Trouble	
Blood Disease		Frequent Cough		Kidney Problems		Spina Bifida	
Blood Transfusion		Frequent Diarrhea		Leukemia		Stomach/Intenstinal Disease	
Breathing Problems		Frequent Headaches		Liver Disease		Stroke	
Bruise Easily		Genital Herpes		Low Blood Pressure		Swelling of Limbs	
Cancer		Glaucoma		Lung Disease		Thyroid Disease	
Chemotherapy		Hay Fever		Mitral Valve Prolaspe		Tonsillitis	
Chest Pains		Heart Attack/Failure		Osteoporosis		Tuberculosis	
Cold Sores/Fever Blisters		Heart Murmur		Pain in Jaw Joints		Tumors/Growths	
Congenital Heart Disorder		Heart Pacemaker		Parathyroid Disease		Ulcers	
Convulsions		Heart Trouble/Disease		Psychiatric Care		Veneral Disease	
						Yellow Jaundice	
Have you had any serious illness not listed?							

Patient, Parent or Guardian Signature:____

Date: ________________________________