

Patient Medical History

Patient Name _____

Physician _____ Phone _____

Date of Last Exam _____

Are you under medical treatment now? Yes _____ No _____

Have you been Hospitalized for any surgical procedure or serious illness in the last 5 years? If yes, please explain _____

Are you taking medications? please list _____

Have you ever taken:

Fen-Fen last date taken _____

Redux last date taken _____

Fosamax last date taken _____

Boniva last date taken _____

Actonael last date taken _____

Any med containing biphosphonates last date taken _____

Viagra last date taken _____

Revati last date taken _____

Cialis last date taken _____

Levitra last date taken _____

Do you use tobacco? Yes _____ No _____ how often? _____

Do you use controlled substances? Yes _____ No _____

Are you wearing contact lenses? Yes _____ No _____

Are you allergic or had any reactions to the following:

Local Anesthetics(Novocain,etc) Yes _____ No _____

Any antibiotics-please list _____

Sulfa Drugs Yes _____ No _____

Barbiturates Yes _____ No _____

Sedatives Yes _____ No _____

Iodine Yes _____ No _____

Aspirin Yes _____ No _____

Any Metals(nickel,mercury,etc.) Yes _____ No _____

Latex Rubber Yes _____ No _____

Any other allergies? _____

Do you have or have you had any of the following?

High Blood Pressure	yes__no__	Emphysema	yes__no__
Heart Attack	yes__no__	Cancer	yes__no__
Rheumatic Fever	yes__no__	Arthritis	yes__no__
Swollen Ankles	yes__no__	Joint Replacment	yes__no__
Fainting/Seizures	yes__no__	Hepatitis	yes__no__
Asthma	yes__no__	Sexually Transmitted Disease	yes__no__
Low Blood Pressure	yes__no__	Stomach Troubles/Ulcers	yes__no__
Epilepsy	yes__no__	Chest Pains	yes__no__
Leukemia	yes__no__	Easily Winded	yes__no__
Diabetes	yes__no__	Stroke	yes__no__
Kidney Disorders	yes__no__	Allergies	yes__no__
AIDS/HIV infection	yes__no__	Tuberculosis	yes__no__
Thyroid Problem	yes__no__	Radiation Therapy	yes__no__
Heart Disease	yes__no__	Glaucoma	yes__no__
Cardiac Pacemaker	yes__no__	Recent Weight Loss	yes__no__
Heart Murmur	yes__no__	Liver Disease	yes__no__
Angina	yes__no__	Heart Trouble	yes__no__
Frequently Tired	yes__no__	Respiratory Problems	yes__no__
Anemia	yes__no__	Mitral Valve Prolapse	yes__no__
Other	yes__no__		

Women only:

Are you pregnant or think you might be pregnant? Yes_____No_____

Are you nursing? Yes_____No_____

Are you taking Oral Contraceptives? Yes_____No_____
