Medical History

Name:_____Birth date:_____ Date of last medical exam:_____
Nature of any health care being received:_____
List all physicians seen in the last 5 years:

Name Phone # or Hospital

_____
_____
_____

Allergies: Anesthetics Latex Penicillin Tetracycline Aspirin Codeine Metals Others:_____
Type of reaction:_____
Current medications and dosages (please list all) :_____
_____
_____
_____
_____

Pre-medication Requirements:_____
Do you use Tobacco? Y/N Type:_____How much:_____How Long:_____
Do you now have or have you ever been diagnosed with the following:

Y/N **AIDS/HIV+**	Y/N **Anemia**	Y/N **Arthritis**
Y/N **Artificial Valves**	Y/N **Artificial Joints**	Y/N **Asthma**
Y/N **Bleeding Disorders**	Y/N **Cancer/Chemotherapy**	Y/N **Cortisone treatments**
Y/N **Congenital Heart Defects**	Y/N **Diabetes**	Y/N **Drug Abuse, Type:**
Y/N **Epilepsy/Seizures**	Y/N **Fainting/Dizzy spells**	Y/N **Frequent Headaches**
Y/N **Glaucoma**	Y/N **Heart Pain/Angina**	Y/N **Heart Attack**
Y/N **Heart Murmur, Type:**	Y/N **Herpes**	Y/N **Hepatitis, Type:**
Y/N **High Blood Pressure**	Y/N **Kidney disease/malfunction**	Y/N **Liver disease**
Y/N **Mitral valve prolapse**	Y/N **Nervous problems**	Y/N **Osteoporosis**
Y/N **Pacemaker**	Y/N **Psychiatric disorders**	Y/N **Radiation treatment:**
Y/N **Rheumatic fever**	Y/N **Respiratory disease**	Y/N **Shortness of breath**
Y/N **Sinus trouble**	Y/N **Stroke**	Y/N **Surgical implants, Type:**
Y/N **Thyroid disease**	Y/N **Tuberculosis**	Y/N **Ulcer/colitis**

Other Conditions not listed or Further Explanation of above Conditions: _____
_____

Have you had or been treated for: Multiple Myelonma, Metastatic Cancer, Pagets Disease, or Osteoporosis with IV bisphosphonates (Aredia, Zometa) or oral bisphosphonates (Actonel, Boniva, Fosamax, Skelif, Didronel)? When and for how long?

Women Only: Are you now or is there any chance you are pregnant? Y/N
Are you taking birth control medications? Y/N
Are you nursing? Y/N

Herbal supplements taken regularly:_____

Patient signature and date:_____

Medical History Update:

Changes	Notes (official use only)	Date	**Patient signature**	Provider Signature
Y/N				
Y/N				
Y/N				
Y/N				
Y/N				
Y/N				