Medical History

Physician's Name: _____ Phone#: _____

1. Have you ever been hospitalized (if yes, explain below)? Yes No

_____

2. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, what for?

_____

3.Have you ever had any excessive bleeding requiring special treatment? Yes No

4**. Women:** Are you pregnant/trying to get pregnant/breast feeding? Yes No

5. Are you allergic to or have you had an allergic reaction to any of the following: (please circle if yes)

Local Anesthetic Penicillin Codeine

Latex Acrylic Metals

Other:_____

6. Are you taking or have you ever taken any of the following medications:
(please circle if yes)

Fosamax Actonel Boniva

7. Please list other medications you are taking:

_____

_____

_____

Have you ever had any of the following?

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting/Dizziness	Yes No	Steroid Treatment	Yes No
Angina Pectoris	Yes No	Eating Disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Dental Implant	Yes No
Liver Disease	Yes No	Persistent Cough	Yes No	Dentures/Partials	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
Heart Murmur	Yes No	Asthma	Yes No	HIV+, AIDS, ARC	Yes No
Rheumatic Fever	Yes No	Hepatitis A	Yes No	Hay Fever	Yes No
Hepatitis B	Yes No	Tobacco Products	Yes No		
Sickle Cell Disease	Yes No	Hepatitis C or D	Yes No	Bruise Easily	Yes No
Sinus Trouble	Yes No	Pacemaker	Yes No	Jaundice	Yes No
Artificial Joints	Yes No	Night Sweats	Yes No	Kidney Trouble	Yes No
Thyroid Disease	Yes No	Stroke	Yes No	Diabetes	Yes No
Anemia	Yes No	Drug Addiction	Yes No	Chemotherapy	Yes No
Blood Transfusion	Yes No	Cold Sores	Yes No	Cancer	Yes No
Mitral Valve Prolapse (MVP)	Yes No			Psychiatric Treatment	Yes No
Radiation Therapy	Yes No			Organ Transplant	Yes No