MEDICAL HISTORY

DATE OF LAST DOCTOR APPT_____

HEIGHT_____WEIGHT_____

DO YOU HAVE, HAVE YOU HAD:

	YES	NO
HEPATITIS OR LIVER DISEASE…….	____	____
EPILEPSY, CONVULSIONS OR SEIZURES…… …	____	____
RHEUMATIC FEVER…….....	____	___
KIDNEY OR BLADDER DISEASE……	____	____
DIABETES……	____	____
TUBERCULOSIS OR EMPHYSEMA…	____	____
HEART ATTACK……	____	____
HEART TROUBLE……..	____	____
HEART MURMUR……..	____	____
STROKE……..	____	____
HIGH/LOW BLOOD PRESSURE……	____	____
SHORTNESS OF BREATH……	____	____
SWOLLEN ANKLES……	____	____
CHEST PAINS (ANGINA) ……	____	____
ALLERGIES……..	____	____
CANCER……..	____	____
CHEMOTHERAPY/RADIATION THERAPY…….	____	____
HOSPITALIZATION FOR ILLNESS OR INJURY……..	____	____
SURGERY……..	____	____
GLAUCOMA……..	____	____
HEMOPHILIA…….	____	____
ARTHRITIS……..	____	____
LUPUS……..	____	____
PSYCHIATRIC TREATMENT……..	____	____
THYROID TROUBLE……..	____	____
STOMACH ULCERS……..	____	____
SINUS PROBLEMS……..	____	____
ASTHMA……..	____	____
ANEMIA……..	____	____
HEART VALVE REPLACEMENT…….	____	____
HIP OR KNEE REPLACEMENT……..	____	____
OTHER PROSTHETIC DEVICE……..	____	____
HIV POSITIVE……..	____	____
AIDS……..	____	____
HIGH RISK FOR HIV INFECTION…... (E.G. INTRAVENOUS DRUG USE, OR BLOOD TRANSFUSION)	____	____

ANY SERIOUS ILLNESS NOT LISTED?_____

_____

LIST ALL MEDICATIONS AND DOSES YOU TAKE NOW

_____

_____

_____

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT_____

_____

IF FEMALE, ARE YOU NOW:	YES	NO
PREGNANT…… …..	____	____
TAKING BIRTH CONTROL…… .	____	____
THROUGH MENOPAUSE……..	____	____
NURSING ----------	____	____

DO YOU HAVE/HAVE YOU HAD AN UNFAVORABLE REACTION TO:		
ASPIRIN……	____	____
BARBITUATES……	____	____
SCOPOLAMINE……..	____	____
GENERAL ANESTHESIA……..	____	____
LOCAL (DENTAL) ANESTHETIC…….	____	____
PENICILLIN OR AMOXICILLIN……..	____	____
ERYTHROMYCIN……..	____	____
TETRACYCLINE OR DOXYCYCLINE.	____	____
OTHER ANTIBIOTICS……..	____	____

IF YES WHICH ONES_____

CODEINE……..	____	____
DEMEROL……	____	____
VICODIN……..	____	____
OTHER PAIN MEDICATIONS……..	____	____
ANY OTHER DRUGS……	____	____

WHICH_____

ARE YOU:

PRESENTLY UNDER A PHYSICIAN'S CARE……	____	____
TAKING ANY MEDICATIONS OR WITH IN THE PAST YEAR SUCH AS:		
ANTIBIOTICS……..	____	____
ANTICOAGULANTS……..	____	____
ANTIDEPRESSANTS……	____	____
ASPIRIN……..	____	____
BLOOD PRESSURE MEDICATION….	____	____
CORTISONE/OTHER STEROID……	____	____
DIABETES TABLETS……	____	____
HORMONE MEDICATION……	____	____
INSULIN..……	____	____

OTHER:

SUBJECT TO FREQUENT URINATION……	____	____
OFTEN THIRSTY……	____	____
SUBJECT TO PROLONGED BLEEDING AFTER INJURY ……..	____	____

HAVE YOU EVER TAKEN PRESCRIPTION DIET PILLS (FEN-PHEN, REDUX)…….. ____ ____

HAVE YOU EVER TAKEN ANY OF THE MEDS: FOSAMAX(osteoporosis), BONEFOS, ZOMETA, AREDIA, ACTONEL…… _____ ____

I confirm that all of the above information is correct to the best of my knowledge.

X_____ Date:____

PATIENT'S OR LEGAL GUARDIAN'S SIGNATURE