Patient Name: _____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

If Yes, please explain: _____

Describe your current physical health: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Do you use controlled substances? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Have you ever taken any cancer medications containing bisphosphonates? ☐ Yes ☐ No

☐ Zometa ☐ Aredia ☐ Other _____

Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? ☐ Yes ☐ No

Have you had any orthopedic total joint replacement? ☐ Yes ☐ No
Date: _____

Please list any serious medical condition)s) that you may have ever had:

_____

Have you ever had any of the following diseases or medical problems?

- ☐ Abnormal Bleeding
- ☐ Allergies
- ☐ Angina Pectoris
- ☐ Artificial Bones
- ☐ Asthma
- ☐ Cancer/Chemotherapy
- ☐ Congenital Heart
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Epilepsy
- ☐ Fever Blisters
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ Hepatitis B
- ☐ HIV + (AIDS)
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pneumocytes
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Stroke/Heart Disease
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart
- ☐ Blood Transfusion
- ☐ Colitis
- ☐ Cosmetic Surgery
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Hay Fever
- ☐ Heart Surgery
- ☐ Hepatitis A
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Yellow Jaundice

For Women:
Are you pregnant or think your pregnant? ☐ *Yes* ☐ *No*
If yes, Due Date: _____
Are you nursing? ☐ *Yes* ☐ *No*
Are you taking oral contraceptives? ☐ *Yes* ☐ *No*

Are you allergic to or have any reactions to any of the following:

☐ Aspirin ☐ Erythromycin ☐ Tetracycline ☐ Codeine ☐ Latex ☐ Novocain ☐ Penicillin

☐ Other _____ ☐ Jewelry ☐ Metals ☐ Dental Anesthetics ☐ None

Please list any other drugs that you are allergic to: _____

Patient Signature: _____ Date: _____

MEDICAL HISTORY REVIEW

Dr. Signature: _____ Date: _____