MEDICAL HISTORY

Patient Name: _____ Date of Birth: __/__/___

Medical Doctor Name: _____ Last Physical Exam: __/__/___

PLEASE ANSWER THE FOLLOWING QUESTIONS

List all medications, herbal remedies, and nicotine replacement therapy that you are taking, including over the counter medications:	List all substances that you are ALLERGIC to:

Do you now have, OR have you ever had, any of the following? Circle 'Y' for yes or 'N' for no:

AIDs	Y N	Epilepsy/Seizures	Y N	Joint replacement	Y N
Anemia	Y N	Fen-Fen Redux	Y N	Kidney disease	Y N
Anxiety disorders	Y N	Gastro-esophageal reflux	Y N	Liver disease	Y N
Arthritis	Y N	Glaucoma	Y N	Psychiatric treatment	Y N
Artificial heart valves	Y N	Heart murmur	Y N	Pacemaker	Y N
Asthma	Y N	Heart surgery	Y N	Sensitivity to metals or latex	Y N
Bisphosphonates (Fosamax)	Y N	Heart trouble	Y N	Sexually transmitted diseases	Y N
Osteoporosis treatment	Y N	Hepatitis (type _____)	Y N	Sinus trouble	Y N
Cancer or tumor	Y N	High blood pressure	Y N	Stroke	Y N
Diabetes	Y N	HIV positive	Y N	Tuberculosis	Y N

1. Have you been treated by a physician or hospitalized in the past year? ..... Y N
   If Y, explain: _____
2. Has there been any change in your general health in the past year? ..... Y N
   If Y, explain: _____
3. Are you experiencing any unresolved stress? ..... Y N
4. Have you ever had any unusual reaction to "Novocain" or other local anesthetic? ..... Y N
5. Have you ever had problems with prolonged bleeding from a cut, injury, or tooth extraction? ..... Y N
6. Are you in a substance abuse recovery program? ..... Y N
7. Have you ever used, or are you currently using any narcotic or recreational drugs? ..... Y N
8. Are you pregnant or possibly pregnant? If Y, when due: _____ Y N
9. Are you taking birth control pills or other hormones? ..... Y N
10. Is there anything related to your health history that you have not indicated above? ..... Y N
    If Y, explain: _____
11. Have you ever used, or are you currently using, Tobacco? ..... Y N
    If Y: How often per day? _____ Start date: __/__/___ Quit date: __/__/___ Would you like to quit? Y N
12. What is the usual amount of alcohol that you consume per day? _____, per week? _____, per month? _____
13. **Please list all major surgeries and/or hospitalizations:**

    _____

    _____

    _____

Patient/Guardian Signature: _____ Date: __/__/___

***** Please complete the other side of this form ****