

## Medical Information

Have you been a patient in the hospital during the last five years? YES NO  
 Explain: \_\_\_\_\_

**Medications:**

Are you **now** taking any vitamins, herbs, prescription or non-prescription drugs? YES NO  
 If yes, please list:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Your Physician's Name and Address: \_\_\_\_\_

Indicate which of the following you had or have at the present. Please circle "yes or no" to each item.

Seizures	YES	NO	Ulcers	YES	NO	Hepatitis A (infectious)	YES	NO	
Heart Disease/Attack	YES	NO	Diabetes	YES	NO	Hepatitis B (serum)	YES	NO	
Angina Pectoris	YES	NO	Thyroid Problems	YES	NO	Hepatitis C	YES	NO	
Cong. Heart Disease	YES	NO	Hearing Difficulties	YES	NO	Venereal Disease	YES	NO	
Heart Murmur	YES	NO	Cancer	YES	NO	A. I. D. S.	YES	NO	
High Blood Pressure	YES	NO	Emphysema	YES	NO	H. I. V. Positive	YES	NO	
Arteriosclerosis	YES	NO	Chronic Cough	YES	NO	Cold/Fever Blisters	YES	NO	
Mitral Valve Prolapse	YES	NO	Tuberculosis	YES	NO	Blood Transfusion	YES	NO	
Artificial Heart Valve	YES	NO	Asthma	YES	NO	Hemophilia	YES	NO	
Heart Pacemaker	YES	NO	Stroke	YES	NO	Anemia	YES	NO	
Heart Surgery	YES	NO	Sinus Trouble	YES	NO	Bruise Easily	YES	NO	
Previous Heart Infection	YES	NO	Radiation Therapy	YES	NO	Liver Disease	YES	NO	
Rheumatic Fever	YES	NO	Chemotherapy	YES	NO	Epilepsy	YES	NO	
Arthritis	YES	NO	Speech Problems	YES	NO	Fainting/ Dizzy Spells	YES	NO	
Kidney Trouble/Dialysis	YES	NO	Artificial Joints	YES	NO	Tumors	YES	NO	
Lupus Erythematisis	YES	NO	Previous Joint Infection	YES	NO	Transplant(s)	YES	NO	
If you had cancer/chemotherapy were you given IV Areadia, Zometa or any other bisphosphoates?							UNCERTAIN	YES	NO

Do you have or have you had any disease, condition, or problem not listed? YES NO

If yes, please list: \_\_\_\_\_

**Allergies:**

Circle if you are allergic OR have had a reaction to any of the following:

Aspirin	Codeine or Other Narcotics	Dental Anesthetics	Erythromycin	Sulfa
Iodine	Latex	Vinyl	Penicillin	Tetracycline

Do you have any other allergies?

If yes, please list: \_\_\_\_\_

**For Women only:**

Are you pregnant? Yes \_\_\_ Week #? \_\_\_ No \_\_\_ Are you nursing? Yes \_\_\_ No \_\_\_ Are you taking birth control pills? Yes \_\_\_ No \_\_\_  
 Warning: \* Be advised that antibiotics may render birth control pills inactive for up to 30 days. Other birth control measures should be used during this time.

\_\_\_\_\_  
**Printed Patient Name**

\_\_\_\_\_  
**Patient (or Responsible Party) Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or Responsible Party**

\_\_\_\_\_  
**Relationship to Patient**

**For Office Use:** Reviewed by Dr. \_\_\_\_\_ Date \_\_\_\_\_