PATIENT MEDICAL HISTORY

Physician: ______________________________

Office Phone: ______________________________

Date of Last Exam: ______________________________

1. Are you allergic to or have you had any reactions to the follow:

	Yes	No
Local Anesthetics (e.g. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Aspirin	☐	☐
Codeine or other narcotics	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐

Other (please list): ______________________________

Women Only:

- Are you pregnant or think you may be pregnant? ☐ ☐
- Are you taking hormone replacement? ☐ ☐
- Are you taking oral contraceptive? ☐ ☐

2. Are you under medical treatment now? ☐ ☐

3. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain ☐ ☐

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4. Do you take medications for Osteoporosis?
☐ Yes ☐ No
If yes: ☐ Actonel ☐ Boniva
☐ Skelid ☐ Didronel ☐ Fosamax

5. Are you taking any medication(s) including non- prescription medication? ☐ Yes ☐ No
If yes, what medication(s) are you taking? ____________

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6. Have you ever taken Ephedrine?
☐ Yes No ☐

7. Do you use tobacco (smoking, snuff, chew)?
☐ Yes No ☐

8. Do you use alcohol daily?
☐ Yes No ☐

9. Have you ever been treated for alcohol or substance abuse?
☐ Yes No ☐

10.Are you wearing contact lenses?
☐ Yes No ☐

11 .Do you have or have you had any of the following?

	Yes	No
AIDS or HIV Infection	☐	☐
Hemophilia	☐	☐
Leukemia	☐	☐
Anemia	☐	☐
Cancer/ chemotherapy/ radiation treatment	☐	☐
Hepatitis/ Jaundice	☐	☐
Liver Disease	☐	☐
Tuberculosis	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Defibrillator	☐	☐
Angina	☐	☐
Chest pains	☐	☐
Mitral Valve Prolapse	☐	☐
Artificial Heart Valve	☐	☐
High Blood Pressure/ Low Pressure	☐	☐
Stroke	☐	☐

	Yes	No
Autoimmune diseases, systemic lupus, other	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Respiratory Problems	☐	☐
Easily Winded	☐	☐
Swollen Ankles	☐	☐
Fainting/ Seizures	☐	☐
Epilepsy/ Convulsions	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
Thyroid Problem	☐	☐
Frequently Tired	☐	☐
Arthritis/ rheumatoid arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Stomach Troubles/ Ulcers	☐	☐
Hay Fever/ allergies	☐	☐
Glaucoma	☐	☐
Recent weight Loss	☐	☐
Sexually Transmitted Disease	☐	☐
Other	☐	☐

Do you have any disease, condition, or problem not listed above that you think I should know about?

Explain____

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