MEDICAL HISTORY

PATIENT NAM	/IE	Birth Date		
				y. Health problems that you may ive. Thank you for answering the
Ave you ever been hospital Have you ever had Are you taking an Do you take, or have you Have you ever taken Foo other medications	ized or had a major operation? a serious head or neck injury? y medications, pills, or drugs? bu taken, Phen-Fen or Redux? samax, Boniva, Actonel or any containing bisphosphonates? Are you on a special diet? Do you use tobacco? bu use controlled substances? he following?	Yes No If yes, plea Yes No If yes, plea Yes No If yes, plea Yes No Yes No Yes No Yes No Yes No	ase explain:ase e	
Do you have, or have you AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Arthritis/Gout Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Transfusion Breathing Problem Bruise Easily Cancer Chemotherapy Have you ever had any see		Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure High Cholesterol Hives or Rash Yes No If yes, pleas	Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Osteoporosis Pain in Jaw Joints Parathyroid Disease Psychiatric Care Radiation Treatments Recent Weight Loss Renal Dialysis e explain:	Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice
To the best of my knowle		have been accurately answ	ered. I understand that provid	ing incorrect information can be
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