Medical History

Please list all medications you take (Prescriptions and Over-the-Counter):_____

Please list all allergies (Medicine and other):_____

Please list all surgeries and medical conditions you have had:_____

Please circle any medical disease, condition or procedure you have ever had:

Heart Attack/Stroke
Heart Surgery/Pacemaker
Heart Murmur
Heart Disease
Artificial Heart valves
Mitral Valve Prolapse
Congenital Heart Defect
High or Low Blood Pressure
Chest Pains
Asthma
Difficulty Breathing
Respiratory Problems
Rheumatic Fever
Scarlet Fever
Chicken Pox
Shingles
Nervousness
Psychiatric Disorder
Alcohol/Drug Abuse
Thyroid Conditions
Kidney Conditions
Liver Conditions
Anemia
Sexually Transmitted Disease
Tuberculosis (TB)
Sinus Conditions
Stomach Ulcers/Gastrointestinal Conditions
Emphysema
Liver Condition
Hepatitis
Cancers/Tumors
Chemotherapy
X-ray/Radiation Treatment
Cosmetic Surgery
Jaw Problems (TMJ)
Frequent Neck Pain
Back Conditions
Arthritis/Rheumatism
Artificial Bones/Joints
HIV+/AIDS/ARC
Fainting/Seizures/Epilepsy
Severe/Frequent Headaches
Diabetes
Bleeding Condition
Glaucoma
Dental Implants

Who is your primary care Physician?_____

Do you use Tobacco? If so, how long, what type and how much:_____

Have you ever taken Phen-fen or Redux?_____.

Women:
Do you take Birth Control Pills? YES NO
Are you Pregnant? YES NO Due date? _____.
Are you nursing? YES NO
Have you ever taken medication (Bisphosphonates) for Osteoporosis (IE: Fosamax, Actonel, Boniva)? YES NO

Please explain:_____