HEALTH AND MEDICAL HISTORY PATIENT NAME: _____ DATE: DR.'S PHONE # DATE OF LAST MEDICAL EXAM: PHYSICIAN: Please check yes or no: 1. Are you under medical treatment now? □ YES □ NO 2. Have you ever been hospitalized for any surgical operation or serious illness? □ YES 3. Are you taking any medications? □ YES □ NO If yes, list them: □ YES □ NO 4. Do you smoke? 5. Do you use cocaine, meth or other drugs? ☐ YES ☐ NO 6. Have you taken Phen-phen? □ YES □ NO 7. Have you taken Di-phosphonates for osteoporosis? □ YES □ NO 8. Are you allergic to or have had any reactions to the following: Check if yes: _Local anesthetic Sedatives Latex Aspirin Penicillin Iodine Barbituates Sulfa Other: 9. WOMEN ONLY: • Are you pregnant or think you may be pregnant? □ YES □ NO Are you nursing? □ YES □ NO Are you taking birth control pills? ☐ YES ☐ No Do you have or have you had any of the following? (check yes or no) YES NO YES NO YES NO □ □ High Blood Pressure Leukemia □ □ Arthritis □ □ Heart Attack Diabetes Joint Replacement or implant ☐ Heart Disease ПП Kidney Disease Hepatitis/Jaundice П □ Pacemaker □ AIDS/HIV Infection Sexually Transmitted Disease StomachTroubles/ Ulcers П Heart Murmur □ □ Thyroid Problem Chest Pain or Angina Frequently Tired П **Tuberculosis** □ Stroke □ □ Anemia Glaucoma □ Rheumatic Fever Emphysema Recent Weight Loss ☐ Swollen Ankles Difficulty Breathing Back/ Neck Problems □ Fainting or Seizures Hay Fever/ Allergies Epilepsy/ Convulsions **Radiation Treatment** □ Asthma Respiratory Problems □ Low Blood Pressure □ □ Cancer Additional medical conditions: I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Signature: Date: **FOR STAFF USE ONLY:** MEDICAL ALERT: _____ Dr. Signature: ____ Date: **MEDICAL HISTORY UPDATES:** Changes in Med Hx:

Date:

Signature: