Medical History

Date:________________ M☐ S☐ W☐ D☐

First Name ___________________________ Last Name___________________________ M ____

Address ____

Home # __________________________ Work# ___________________________ Cell# ____

Birthdate________________ Male ___ Female ___ Social Security ____

Insurance Primary Policy Holder _________________________________ Employer ____

Insurance ID # __________________________________ Group# ____

Spouse Name ___________________ Birthday ___________ Social Security ____________ Spouse cell# ________________________________

Are you under a Physician's care? Yes☐ No☐ If yes List ____

Have you had any surgeries? Yes☐ No☐ If yes List ____

Have you had any serious head or neck injury? Yes☐ No☐ If yes List ____

Are you taking any medications, pills, drugs? Yes☐ No☐ If yes List ____

Have you ever taken Fosamx, Boniva, Actonel or other medications containing bishosphonates? Yes___ No___ If yes List:____________________

Are you on a special diet? Yes☐ No☐ If yes List ____

Do you use tobacco of any kind? Yes☐ No☐ If yes List ____

Do you use any controlled substances? Yes☐ No☐ If yes List ____

Are you pregnant? Yes☐ No☐

Are you allergic to any medications? Yes☐ No☐ If yes List ____

Are you allergic to latex? Yes☐ No☐

Do you have, or have you had, any of the following?

Aids/HIV Positive	Yes☐	No☐	Fainting Spells	Yes☐	No☐	Osteoporosis	Yes☐	No☐
Alzheimer's Disease	Yes☐	No☐	Frequent Cough	Yes☐	No☐	Pain in Jaw Joints	Yes☐	No☐
Ana phylaxis	Yes☐	No☐	Frequent Diarrhea	Yes☐	No☐	Psychiatric Care	Yes☐	No☐
Anemia	Yes☐	No☐	Frequent Headaches	Yes☐	No☐	Radiation Treatment	Yes☐	No☐
Angina	Yes☐	No☐	Genital Herpes	Yes☐	No☐	Recent Weight Loss	Yes☐	No☐
Arthritis/ Gout	Yes☐	No☐	Glaucoma	Yes☐	No☐	Renal Dialysis	Yes☐	No☐
Artificial Joints	Yes☐	No☐	Heart Attack/Failure	Yes☐	No☐	Rheumatic Fever	Yes☐	No☐
Asthma	Yes☐	No☐	Heart Murmur	Yes☐	No☐	Scarlet Fever	Yes☐	No☐
Blood Disease	Yes☐	No☐	Heart Pacemaker	Yes☐	No☐	Shingles	Yes☐	No☐
Blood Transfusion	Yes☐	No☐	Heart trouble	Yes☐	No☐	Sickle Cell Disease	Yes☐	No☐
Breathing Problems	Yes☐	No☐	Hemophilia	Yes☐	No☐	Sinus Trouble	Yes☐	No☐
Bruise Easily	Yes☐	No☐	Hepatitis A	Yes☐	No☐	Spina Bifida	Yes☐	No☐
Cancer	Yes☐	No☐	Hepatitis B or C	Yes☐	No☐	Stomach or Intestinal Disease	Yes☐	No☐
Chemotherapy	Yes☐	No☐	Herpes	Yes☐	No☐	Stroke	Yes☐	No☐
Chest Pains	Yes☐	No☐	High Blood Pressure	Yes☐	No☐	Swelling of Limbs	Yes☐	No☐
Cold Sores/Fever Blisters	Yes☐	No☐	High Cholesterol	Yes☐	No☐	Thyroid Disease	Yes☐	No☐
Congenital Heart Disorder	Yes☐	No☐	Hives or Rash	Yes☐	No☐	Tuberculosis	Yes☐	No☐
Convulsions	Yes☐	No☐	Hypoglycemia	Yes☐	No☐	Tumors or Growths	Yes☐	No☐
Diabetes	Yes☐	No☐	Irregular Heartbeat	Yes☐	No☐	Weers	Yes☐	No☐
Drug Addiction	Yes☐	No☐	Kidney Problems	Yes☐	No☐	Venereal Disease	Yes☐	No☐
Emphysema	Yes☐	No☐	Leukemia	Yes☐	No☐	Have you ever had serious illnesses not		
Epilepsy/Seizures	Yes☐	No☐	Low Blood Pressure	Yes☐	No☐	listed above? ______________________		
Excessive Bleeding	Yes☐	No☐	Lung Disease	Yes☐	No☐	______________________________		
Excessive Thirst	Yes☐	No☐	Mitral Valve Prolapse	Yes☐	No☐	______________________________		

Signature of Patient, Parent or Guardian: ____