MEDICAL HISTORY

Physician's name and address _____
Date of last physical exam _____ Are you under medical care now? Yes___ No___
Have you been in the hospital in the past 5 years? Yes__No__ For what? _____
Are you taking any medicine? Yes__No__ For What? _____
What medicines? _____
_____
Are you taking Fosamax, Boniva or any other Bisphosphonates? Yes___ No___
Are you allergic to any medications? Yes__No__ What are they? _____
Are you allergic to any metals? Yes__No___ What type? _____
Are you on a special diet? Yes__No___ Are you pregnant? Yes__No__ If yes, due date is _____
Are you in good health? Yes__No___ Do you use an inhaler? Yes__No__

Do you have any of the following?

Yes__No__ Blood Disease/Anemia	Yes__No__ Diabetes	Yes__No__ Stomach, Intestinal Disease
Yes__No__ Rheumatism/Arthritis	Yes__No__ Cancer	Yes__No__ Stroke
Yes__No__ Hepatitis/Liver Disease	Yes__No__ Radiation Treatment	Yes__No__ Aids
Yes__No__ Epilepsy/Seizures	Yes__No__ Thyroid Conditions	Yes__No__ Head or Jaw Injury
Yes__No__ Cognitive Disabilities	Yes__No__ High Blood Pressure	Yes__No__ Kidney disease/Jaundice
Yes__No__ Mental Health Conditions	Yes__No__ Pacemaker	Yes__No__ Birth Control
Yes__No__ Prolonged Bleeding	Yes__No__ Blood Transfusions	Yes__No__ Heart Trouble
Yes__No__ Drug/Alcohol Abuse	Yes__No__ Tumors/Growths	Yes__No__ Other Serious Illnesses
Yes__No__ Difficulty with sight	Yes__No__ Hard of Hearing	Yes__No__ Artificial Joints
Yes__No__ Fainting/Nervousness		

Yes__No__ Premedication (For what?) _____

COMMENTS or CONCERNS:

_____

_____

Signature: _____ **Date:** _____