MEDICAL HISTORY

PATIENT NAME: _____
Last First MI Date of birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER. PLEASE WRITE "DON'T KNOW" ON THE AFTER THE QUESTION

1. Physician's name: _____
   Address: _____
   _____
2. Are you under a physician care? ……..... YES NO
   Since when_____ Why_____
3. When was your last complete physical exam? _____
4. Are you taking any medications or substances? ..... YES NO
   (If yes, please list medications in the comments section)
5. Are you taking Fosamax or Alendronate? ..... YES NO
6. Are you allergic to any medications or substances? ……..... YES NO
7. Do you have any other allergies? .....…… YES NO
8. Do you have problem with penicillin, antibiotics, anesthetics or other medications? ……... YES NO
9. Are you sensitive to any metals or latex? ..... YES NO
10. Are you pregnant or suspect you may be? ……..... YES NO
11. Do you use any birth control medications? .....….. YES NO
12. Have you ever been treated for or been told you might have heart disease? YES NO
13. Do you have **a pacemaker** or an **artificial heart valve implant**? ..….. YES NO
14. Have you ever had **rheumatic fever**? ..... YES NO
15. Are you aware of any **heart murmurs**? .....…..... YES NO
16. Do you have low or high blood pressure? ..... YES NO
17. Have you ever had a serious illness or major surgery? ..... YES NO
18. Have you ever had Radiation treatment, chemo treatment for tumor growth or other condition? .....… YES NO
19. Do you have arthritis , rheumatism,or Osteoporosis? ..... YES NO
20. Do you have any **artificial joints/ prosthesis**? ……..... YES NO
21. Do you have any blood disorders, such as anemia or rheumatism? ..... YES NO
22. Have you ever bleed excessively after being cut or injured? …… YES NO
23. Do you have any stomach problem? ……..… YES NO
24. Do you have any kidney problem? ……..... YES NO
25. Do you have any liver problem? ……..... YES NO
26. Are you **diabetic**? ……..... YES NO
27. Do you have **asthma**? ……..... YES NO
28. Do you have epilepsy or seizure disorders? ……..... YES NO
29. Do you or have you had a venereal disease? ..... YES NO
30. Have you tested HIV positive? ……..... YES NO
31. Do you have AIDS? ..... YES NO
32. Have you had or do you test **positive for hepatitis**? …..…..……..... YES NO
33. Do you or have you had **T.B**? ……..... YES NO
34. Do you smoke, chew, use snuff or any other form of tobacco? ……..... YES NO
35. Do you consume alcoholic beverage? ……..... YES NO
36. Do you habitually use controlled substances? ……..... YES NO
37. Have you ever had psychiatric? ……..... YES NO
38. Have you ever taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss product? ……. YES NO
39. Do you have any disease, condition ,or problem not listed? ..... YES NO
    If so, explain _____
40. Is there anything else we should know about your health that we have not covered in this form?.....…… YES NO
41. Would you like to speak to the Doctor privately about any problem? ..... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

_____ _____
PATIENT/ GUARDIAN 'S SIGNATURE DATE

COMMENTS

Update Med. Hx._____

_____
Patient's Signature Date

Update Med. Hx._____

_____
Patient's Signature Date

Update Med. Hx._____

_____
Patient's Signature Date

Update Med. Hx._____

_____
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Update Med. Hx._____

_____
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