Last Name First Name Middle Initial

Physicians Name and Telephone Number

Current Medications and Dosage

Do you have any problem with antibiotics or anesthetics? Yes No

Have you had any of the following medical conditions? (please circle)

No	Yes	Heart Attack / Stroke	No	Yes	High Blood Pressure
No	Yes	Heart Surgery	No	Yes	Low Blood Pressure
No	Yes	Heart Murmur	No	Yes	Epilepsy
No	Yes	Pace Maker	No	Yes	Seizures
No	Yes	Mitral Valve Prolapse	No	Yes	Fainting
No	Yes	Rheumatic Fever	No	Yes	Diabetes Type I Type II
No	Yes	HIV / AIDS	No	Yes	Thyroid Disorder
No	Yes	Hepatitis	No	Yes	Hemophilia
No	Yes	Endocarditis	No	Yes	Blood Transfusion
No	Yes	Osteoporosis	No	Yes	Anemia
No	Yes	Artificial Bones / Joints	No	Yes	Radiation Treatment
No	Yes	Artificial Valves	No	Yes	Kidney Problems
No	Yes	Sinus Problems	No	Yes	Severe Headaches
No	Yes	Asthma	No	Yes	Glaucoma
No	Yes	Difficulty Breathing	No	Yes	Shingles
No	Yes	Do You Smoke	No	Yes	Cancer / Chemotherapy
No	Yes	Emphysema	No	Yes	Recreational Drug Use
No	Yes	Tuberculosis	No	Yes	Do you consume Alcohol
No	Yes	Herpes	No	Yes	Eating disorder
No	Yes	STD's	No	Yes	Psychiatric Problems

Have you ever taken medicine for your bones? No Yes (ie Fosamax, Boniva, Actonel, Aredia)

Are you allergic to any of the following?

No Yes Aspirin
No Yes Penicillin
No Yes Erythromycin
No Yes Latex or Rubber Products
No Yes Codeine
No Yes Tetracycline
No Yes **Other:**

Women:

No Yes Are you pregnant?
No Yes Taking Birth Control Pills
No Yes Nursing
No Yes Hormone Therapy

Please Sign and Date Dr. Initials

Medical History