Medical Information

Patient Name: _____ Today's Date: _____

PERSONAL INFORMATION

Please fill out as accurately as possible

Do you have a Primary Care Dr.? ☐Yes ☐No If Yes _____

Have you been hospitalized or had a major operation? ☐Yes ☐No If Yes_____

Have you ever had a serious head or neck injury? ☐Yes ☐No If Yes _____

Are you currently taking any medications? ☐Yes ☐No If Yes_____

Do you have any allergies to medications? ☐Yes ☐No If Yes_____

Have you ever taken Fosamax, Boniva Actonel, or any other medications containing bisphosphonates? ☐Yes ☐No If Yes _____

_____

The following information is needed to accurately diagnose any condition and to give the highest possible standard of professional service. Please answer honestly and accurately.

Do you have or have you ever had any of the following diseases or problems?

	Yes	No		Yes	No
Arthritis	☐	☐	Kidney Disease	☐	☐
Blood disorders, anemia, problems clotting	☐	☐	Breathing disorder, Asthma etc.	☐	☐
Cancer/Tumors	☐	☐	Nervous disorders	☐	☐
Heart Disease/Heart Murmur	☐	☐	Rheumatic/Scarlet Fever	☐	☐
Heart Attack/ Stroke?	☐	☐	Seizures	☐	☐
High or Low blood pressure	☐	☐	Sinus problems	☐	☐
Hepatitis (A, B, C) Jaundice or Liver disease	☐	☐	Tuberculosis (TB)	☐	☐
Thyroid disease	☐	☐	Ulcers	☐	☐
HIV or AIDS	☐	☐	Do you smoke or use tobacco	☐	☐
Joint replacement (s)	☐	☐	History of substance abuse	☐	☐
Are you pregnant/ Nursing?	☐	☐	Diabetes Type_____	☐	☐

If you answered ***Yes*** to any of the above, please give further details:_____

_____

Any other allergies or illnesses not listed above? _____

List any additional medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Signature Date Dr.'s Signature