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PLEASE CIRCLE--PAST OR CURRENT MEDICAL CONDITIONS

PRIMARY CARE PHYSICIAN_____
PHONE NUMBER_____Location_____
PHARMACY NUMBER_____

YES	NO	HEART PROBLEMS
YES	NO	CHEST PAIN
YES	NO	HEART MURMUR/MVP
YES	NO	HEART VALVE PROBLEM
YES	NO	ARTIFICIAL VALVE (DATE REPLACED)_____
YES	NO	RHEUMATIC FEVER
YES	NO	PACEMAKER(DATE PLACED)_____
YES	NO	BLOOD PROBLEMS
YES	NO	EASY BRUISING
YES	NO	FREQUENT NOSEBLEEDS
YES	NO	ABNORMAL BLEEDING/ANEMIA
YES	NO	BLOOD PRESSURE CIRCLE: HIGH / LOW
YES	NO	BLOOD TRANSFUSION
YES	NO	ALLERGY PROBLEMS
YES	NO	EMPHYSEMA, SHORTNESS OF BREATH
YES	NO	SINUS PROBLEMS
YES	NO	ASTHMA/ TUBERCULOSIS/ BRONCHITIS (CIRCLE)
YES	NO	SKIN RASH/ HAY FEVER
YES	NO	SEASONAL ALLERGIES
YES	NO	TAKE ALLERGY MEDS
YES	NO	INTESTINAL PROBLEMS
YES	NO	ULCERS
YES	NO	KIDNEY/ BLADDER ISSUES
YES	NO	UNUSUAL WEIGHT GAIN/LOSS
YES	NO	REFLUX

YES NO BONE/ JOINT PROBLEMS
YES NO ARTHRITIS/RHEUMATISM
YES NO NECK/ BACK PAIN
YES NO JOINT REPLACMENT
HIP, KNEE, PINS, IMPLANTS DATES

_____

_____

YES NO FAINTING SPELLS/ SEIZURES/ EPILEPSY
YES NO STROKE DATE:_____
YES NO FREQUENT OR SEVERE HEADACHES
YES NO THYROID PROBLEMS CIRCLE: HYPO/ HYPER

YES NO CANCER/TUMORS
TYPE AND LOCATION_____
YES NO RADIATION TREATMENT
DATE OF LAST TREATMENT_____
YES NO CHEMO
DATE OF LAST TREATMENT_____
YES NO INFUSION
DATE OF LAST TREATMENT_____

YES NO DIABETES
YES NO PROSTATE ISSUES
YES NO EXCESSIVE NEED TO URINATE
YES NO DRY MOUTH / CONTROLLED
YES NO HEPATITIS TYPE ____/ JAUNDICE/ LIVER DISEASE
YES NO HERPES / OTHER STD(S)
YES NO HIV POSITIVE/ AIDS
YES NO GLAUCOMA / WEARS CONTACTS
YES NO PSYCHIATRIC CARE / NERVOUS DISORDER
YES NO HISTORY OF ALCOHOL / DRUG ABUSE
YES NO DO YOU SMOKE/ CHEW TOBACCO
HOW OFTEN_____

WOMEN ONLY

YES NO CONTRACEPTIVES
YES NO HORMONES
YES NO PREGNANT DUE DATE_____
YES NO NURSING
YES NO HAVE YOU REACHED MENOPAUSE

ANY CONDITIONS NOT LISTED WE NEED TO KNOW ABOUT:

_____

_____

_____

ALLERGIC TO ANY OF THE FOLLOWING?

YES NO LOCAL ANESTHETIC "NOVOCAINE"
YES NO PENICILLIN
YES NO SULFA DRUGS
YES NO BARBITUATES/ SEDATIVES/ SLEEPING PILLS
YES NO ASPIRIN/ ACETOMINOPHEN/ IBUPROFEN
YES NO CODEINE/ DEMEROL/ NARCOTICS
YES NO METALS TYPE_____
YES NO LATEX/ RUBBER DAM
OTHERS NOT LISTED_____

ARE YOU CURRENTLY OR HAVE YOU TAKEN IN THE PAST ANY OF THESE:

YES NO OSTAC
YES NO SKELID
YES NO ZOMETA
YES NO ACTONEL
YES NO AREDIA
YES NO RECLAST
YES NO BONIVA
YES NO DIDRONAL
YES NO FOSAMAX
HAVE YOU EVER BEEN TREATED FOR OSTEOPOROSIS/ OSTEOPENIA?
PHYSICIAN_____
NUMBER_____

HAVE YOU TAKEN IN THE LAST 12 MONTHS

YES NO ANTIBIOTICS
YES NO SULFA DRUGS
YES NO TRANQUILIZERS
YES NO NITROGLYCERIN
YES NO ASPIRIN/ PAIN MEDS
YES NO CORTISONE(STEROIDS)
IF SO, WHY_____

PATIENT SIGNATURE:_____

DOCTOR SIGNATURE:_____

DATE:_____