Patient Medical History

Name of Physician ______________________ Location ______________ Phone __________

Are you under medical treatment now? Y N

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Y N

If yes, explain ______________________

Are you or have you ever been addicted to a chemical substance? Y N

Have you undergone current or past osteoporosis therapy? Y N
(examples: fosamax, actonel, boniva pill form)

Have you undergone current or past therapy to reduce high blood calcium? (Bisphosphonate therapy?) Y N
(examples: intravenous aredia, zometa)

Are you wearing contact lenses? Y N

Women only

Are you pregnant or think you may be pregnant? Y N

Are you nursing? Y N

Are you taking oral contraceptives? Y N

Allergies:

Aspirin	Y	N
Barbiturates (sleeping pills)	Y	N
Codeine	Y	N
Iodine	Y	N
Latex	Y	N
Local Anesthetic	Y	N
Penicillin	Y	N
Sulfas	Y	N
Any Metals (nickel, mercury, etc.)	Y	N

Other ______________

Are you taking any medication(s) including non-prescription medicine? Y N

List the medication(s) here:

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Do you have or have you had any of the following?

AIDS or HIV infection	Y	N
Anemia	Y	N
Angina / Chest Pains	Y	N
Acquired Valvular Disease or Heart Murmur	Y	N
Arthritis / Rheumatism	Y	N
Artificial Heart Valve Replacement	Y	N
Asthma	Y	N
Bacterial Endocarditis History	Y	N
Blood Disease	Y	N
Cancer Type: ________	Y	N
Cardiac Pacemaker	Y	N
Chemo / Radiation	Y	N
Congenital Heart Disease Type: ________	Y	N
Congestive Heart Failure	Y	N
Cough, Persistent or Bloody	Y	N
Diabetes Type: ________	Y	N
Emphysema	Y	N
Epilepsy / Convulsions	Y	N
Fainting / Seizures	Y	N
Glaucoma	Y	N
Heart Attack	Y	N
Heart Surgery	Y	N
Hepatitis Type: ________	Y	N
High Blood Pressure	Y	N
Jaundice	Y	N
Joint Replacement What? ________ When? ________	Y	N
Kidney Disease	Y	N
Liver Disease	Y	N
Low Blood Pressure	Y	N
Mental Health Condition	Y	N
Mitral Valve Prolapse	Y	N
Organ Transplantation	Y	N
Physical disability that may require special care? (impairment of hearing, sight, speech)	Y	N
Physician Requests Antibiotic Coverage for any reason not listed	Y	N
Recent Weight Loss	Y	N
Respiratory Problems	Y	N
Rheumatic Fever	Y	N
Scarlet Fever	Y	N
Sexually Transmitted Disease	Y	N
Sinus Trouble	Y	N
Stomach Trouble / Ulcers	Y	N
Stroke	Y	N
Swollen Ankles / Feet	Y	N
Systemic Lupus Erythematosus (SLE)	Y	N
Thyroid Problem	Y	N
Tuberculosis / Lung Disease	Y	N

Other ______________________