## **MEDICAL HISTORY**

Have you ever had a serious head or neck injury?	PATIENT NAME		Birth Date		
Have you were had a smajor operation? Yes No I Have you were had a serious head or neck injury? Yes No I Ves No	have, or medication that you may be	-	-		
Pregnant/Trying to get pregnant? \ Yes \ No \ Taking oral contraceptives? \ Yes \ No \ Nursing? \ Yes \ No \ Nursing? \ Yes \ No \ Nursing? \ Yes \ No \ Nu	Have you ever been hospitalized or hat Have you ever had a serious Are you taking any medicat Do you take, or have you taken, Have you ever taken Fosamax, Bother medications containii	Id a major operation? Yes Nead or neck injury? Yes Nead or neck injury? Yes Neditions, pills, or drugs? Yes Neben-Fen or Redux? Yes Neben-Fen or Redux? Yes Neditions, Actonel or any ong bisphosphonates? Yes Nedition on a special diet? Yes Nedition you use tobacco? Yes Nedition	If yes, please explain:		
Are you allergic to any of the following?    Aspirin	Women: Are you			N : 0 0 V 0	. No
Aspirin   Penicillin   Codeine   Local Anesthetics   Acrylic   Metal   Latex   Sulfa drugs			raceptives? Yes No	Nursing? () Yes	NO
AIDS/HIV Positive	Aspirin Penicillin	•	hetics Acrylic	Metal La	tex Sulfa drugs
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be	AIDS/HIV Positive         Yes         No           Alzheimer's Disease         Yes         No           Anaphylaxis         Yes         No           Anemia         Yes         No           Angina         Yes         No           Arthritis/Gout         Yes         No           Artificial Heart Valve         Yes         No           Artificial Joint         Yes         No           Asthma         Yes         No           Blood Disease         Yes         No           Blood Transfusion         Yes         No           Bruise Easily         Yes         No           Cancer         Yes         No           Chemotherapy         Yes         No           Chest Pains         Yes         No           Cold Sores/Fever Blisters         Yes         No           Convulsions         Yes         No	Cortisone Medicine Yes Diabetes Yes Drug Addiction Yes Easily Winded Yes Emphysema Yes Epilepsy or Seizures Yes Excessive Bleeding Yes Excessive Thirst Yes Fainting Spells/Dizziness Yes Frequent Cough Yes Frequent Diarrhea Yes Genital Herpes Yes Glaucoma Yes Heart Attack/Failure Heart Murmur Yes Heart Pacemaker Yes Heart Trouble/Disease	No Hepatitis A Hepatitis A Hepatitis B or C Herpes High Blood Pressure High Cholesterol Hives or Rash Hypoglycemia Hypoglycemia Hypoglycemia Liver Disease Low Blood Pressure Lung Disease No No No No No No Hotel Prolapse Osteoporosis Pain in Jaw Joints No Parathyroid Disease Psychiatric Care	Yes No Yes Yes No Yes N	ght Loss
	Comments:				
					ect information can be