Medical History Update

Last Name: _____ First Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Employer: _____ Insurance Carrier: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

Y	N		Y	N		Y	N	
		Sulfa		☐	Latex	☐	☐	Metals
		Penicillin		☐	Aspirin	☐	☐	Erythromycin
		Codeine		☐	Anesthetic	☐	☐	Other
		Ibuprofen	☐	☐	Iodine			

_____

_____

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Joint Replacement	☐	☐	Liver Disease	☐	☐	Acid Reflux/Ulcers
☐	☐	Congenital Heart Defect	☐	☐	Kidney Disease	☐	☐	Fever Blisters
☐	☐	Artificial Heart Valve	☐	☐	Stroke	☐	☐	Asthma
☐	☐	Heart Transplant	☐	☐	Cancer	☐	☐	Frequent Headaches
☐	☐	Heart Murmur	☐	☐	Diabetes	☐	☐	Thyroid Problems
☐	☐	Bleeding Problems	☐	☐	Osteoporosis	☐	☐	Sleep Apnea/Snoring
☐	☐	Hepatitis - Type? _____	☐	☐	Epilepsy/Seizures	☐	☐	High Blood Pressure
☐	☐	HIV+/AIDS	☐	☐	Psychiatric Treatment	☐	☐	Sinus Trouble
☐	☐	Tuberculosis (TB)						
☐	☐	Anything not listed? _____						

Have you ever taken bisphosphonates, such as but not limited to Fosamax and Boniva? (Y/N) _____

Tobacco use? (Y/N) _____ If yes, what kind and how much? _____

Are you Pregnant/Nursing? (Y/N) _____ If yes, explain: _____

_____ _____

Signature Date