Patient Medical History

Physician_____ Office Phone_____ Date of Last Visit_____

	YES	NO
1. Are you under medical treatment now?	❑	❑
2. Have you been hospitalized for any surgical operation or serious illness within the last five years? If Yes, please explain_____ _____	❑	❑
3. Are you taking any medication(s) including non-prescription drugs? If YES, what are you taking?_____ _____	❑	❑
4. Have you ever taken Fen-Phen/Redux?	❑	❑
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	❑	❑
6. Have you taken Viagra, Revoti, Cialis or Levitra in the last 24 hours?	❑	❑
7. Do you use tobacco?	❑	❑
8. Do you use a controlled substance?	❑	❑
9. Are you wearing contact lenses?	❑	❑
10. Are you allergic or do you have any reactions to the following?		
Local Anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any other antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (Nickel, Mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (please list)_____		
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 5 weeks)?	❑	❑

	YES	NO
12. *Women only:*		
a) Are you pregnant or think you may be?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking contraceptives?	❑	❑
13. Do you have or have you had any of the following?		
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Rheumatic Fever	❑	❑
Swollen Ankles	❑	❑
Fainting/Seizures	❑	❑
Asthma	❑	❑
Low Blood Pressure	❑	❑
Epilepsy/Convulsions	❑	❑
Leukemia	❑	❑
Diabetes	❑	❑
Kidney Disease	❑	❑
AIDS or HIV Infection	❑	❑
Thyroid Problem	❑	❑
Heart Disease	❑	❑
Cardiac Pacemaker	❑	❑
Heart Murmer	❑	❑
Angina	❑	❑
Stomach troubles/Ulcers	❑	❑
Anemia	❑	❑
Emphysema	❑	❑
Cancer	❑	❑
Arthritis	❑	❑
Joint Replacement	❑	❑
Stroke	❑	❑
Allergies/Hay Fever	❑	❑
Tuberculosis	❑	❑
Liver Disease	❑	❑
STD	❑	❑
Hepatitis/Jaundice	❑	❑
Glaucoma	❑	❑