

MEDICAL HISTORY

Your Physician _____ Type _____ Phone _____

DO YOU HAVE OR HAVE EVER HAD: (circle)

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| <p>1. Hospitalization for illness or surgery YES NO</p> <p>2. An allergic reaction..... YES NO</p> <p>3. Any reaction to:</p> <p style="padding-left: 20px;">a. aspirin..... YES NO</p> <p style="padding-left: 20px;">b. penicillin..... YES NO</p> <p style="padding-left: 20px;">c. erythromycin..... YES NO</p> <p style="padding-left: 20px;">d. tetracycline..... YES NO</p> <p style="padding-left: 20px;">e. codeine..... YES NO</p> <p style="padding-left: 20px;">f. sedative or sleeping pills (barbiturates) YES NO</p> <p style="padding-left: 20px;">g. dental anesthetic..... YES NO</p> <p style="padding-left: 20px;">h. any other medication YES NO</p> <p>4. Hepatitis..... YES NO</p> <p>5. Jaundice (yellow skin and eyes)..... YES NO</p> <p>6. Arthritis YES NO</p> <p>7. Venereal disease..... YES NO</p> <p>8. Epilepsy..... YES NO</p> <p>9. Rheumatic fever..... YES NO</p> <p>10. Scarlet fever..... YES NO</p> <p>11. Anemia or other blood disorder..... YES NO</p> <p>12. Prolonged bleeding due to slight cut..... YES NO</p> <p>13. Kidney disease YES NO</p> <p>14. Diabetes..... YES NO</p> <p>15. Stomach or duodenal ulcer YES NO</p> <p>16. Liver disease..... YES NO</p> <p>17. Tuberculosis..... YES NO</p> <p>18. Emphysema..... YES NO</p> <p>19. Thyroid or parathyroid disorders..... YES NO</p> <p>20. Heart trouble..... YES NO</p> <p>21. Heart murmur..... YES NO</p> <p>22. Arteriosclerosis..... YES NO</p> <p>23. High blood pressure..... YES NO</p> <p>24. Low blood pressure..... YES NO</p> <p>If female, are you now:</p> <p>A. Pregnant..... YES NO</p> <p>C. Presently in the menopause (change of life) YES NO</p> | <p>25. Excessively swollen ankles..... YES NO</p> <p>26. A stroke..... YES NO</p> <p>27. Shortness of breath on mild exertion YES NO</p> <p>28. Chest pains on mild exertion..... YES NO</p> <p>29. Hives, skin rash or hay fever..... YES NO</p> <p>30. Asthma..... YES NO</p> <p>31. Emotional problems or tension.... YES NO</p> <p>32. Psychiatric treatment..... YES NO</p> <p>33. A tumor or abnormal growth..... YES NO</p> <p>34. Radiation treatment (cobalt, radium x-ray, etc.)..... YES NO</p> <p>35. Glaucoma YES NO</p> <p>36. Contact lenses YES NO</p> <p>37. Herpes..... YES NO</p> <p>38. AIDS YES NO</p> <p>39. Prostate problems (if male)..... YES NO</p> <p style="text-align: center;">ARE YOU:</p> <p>40. Presently being treated for any illness YES NO</p> <p>41. Taking any medication regularly or within the past year..... YES NO</p> <p>42. Aware of change in your general health in past year..... YES NO</p> <p>43. Aware of any recent weight change YES NO</p> <p>44. Often thirsty..... YES NO</p> <p>45. Urinating more than six times a day YES NO</p> <p>46. Often exhausted and fatigued..... YES NO</p> <p>47. Subject to frequent headaches..... YES NO</p> <p>48. Heavy smoker (1 or more packs day) YES NO</p> <p>49. Generally a nervous person..... YES NO</p> <p>50. Often unhappy or depressed..... YES NO</p> <p>51. Taking Bio/ Bisphosphonates (eg. Aredia, Zometa, Actenol, or Fosamax) YES NO</p> <p>B. Taking birth control pills/hormones YES NO</p> <p>D. Past menopause YES NO</p> |
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PLEASE EXPLAIN FULLY ANY "YES" ANSWER ABOVE:

Patient's Signature _____

Date _____