PATIENT MEDICAL HISTORY

Please circle YES or NO on all questions. If you answer yes, please explain.

Are you presently under a physician's care for any illness or problems?	NO	YES	_____
Have you ever had any surgery?	NO	YES	_____
Did you have general anesthesia?	NO	YES	_____
Have you ever had an unusual or prolonged bleeding after surgery?	NO	YES	_____
After extraction of teeth?	NO	YES	_____
Family history of a bleeding problem?	NO	YES	_____
Do you bruise easily?	NO	YES	_____
Do you have nose bleeds?	NO	YES	_____
Rheumatic Fever?	NO	YES	_____
Heart Trouble	NO	YES	_____
Heart Attack	NO	YES	_____
Heart Murmur	NO	YES	_____
Stroke	NO	YES	_____
Emphysema, asthma, or other lung disease	NO	YES	_____
Diabetes	NO	YES	_____
Cancer	NO	YES	_____
Chemotherapy or radiation	NO	YES	_____
Hepatitis (A, B, or C)	NO	YES	_____
Have you ever TESTED POSITIVE FOR AIDS OR ARC?	NO	YES	_____
Liver or Kidney trouble	NO	YES	_____
Blood pressure problems	NO	YES	_____
Glaucoma	NO	YES	_____
Other serious illness or injury	NO	YES	_____
Do you smoke? How much?	NO	YES	_____
Do you use alcohol? How often?	NO	YES	_____
Are you wearing contact lenses?	NO	YES	_____
Are you taking birth control pills?	NO	YES	_____
Are you pregnant or nursing a baby?	NO	YES	_____
Do you have a cough or cold?	NO	YES	_____
Are you allergic to any drugs or food? LIST	NO	YES	_____
Have you ever had a bad reaction to any drug?	NO	YES	_____
Do you use aspirin? How often? What mgs?	NO	YES	_____
Are you taking blood thinners (Anticoagulants)? LIST	NO	YES	_____
Have you ever taken any osteoporosis drugs?	NO	YES	_____

What medications are you now taking? _____
_____

What medications have you taken in the last 24 months? _____
_____

List other important information about your health that we should know _____
_____
_____

Doctor's Signature_____