PATIENT NAME:____

PRIMARY PHYSICIAN:____________________________________DATE OF LAST VISIT:__________

PLEASE ANSWER "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

HEART PROBLEMS	YES	NO
CHEST PAIN	O	O
SHORTNESS OF BREATH	O	O
BLOOD PRESSURE PROBLEMS	O	O
HEART MURMUR	O	O
HEART VALVE PROBLEM	O	O
RHEUMATIC FEVER	O	O
PACEMAKER	O	O
ARTIFICIAL HEART VALVE	O	O
OTHER_______________		
BLOOD PROBLEMS		
EASY BRUISING	O	O
FREQUENT NOSE BLEEDING	O	O
ABNORMAL BLEEDING	O	O
BLOOD DISEASE (ANEMIA)	O	O
OTHER_______________		
ALLERGY PROBLEMS		
HAY FEVER	O	O
SINUS PROBLEMS	O	O
SKIN RASHES	O	O
TAKING ALLERGY MEDS	O	O
ASTHMA	O	O
OTHER_______________		
BONE OR JOINT PROBLEMS		
ARTHRITIS	O	O
BACK OR NECK PAIN	O	O
JOINT REPLACEMENT	O	O
PINS OR METAL RODS	O	O
OTHER________________		

WOMAN

DO YOU TAKE CONTRACEPTIVES/OTHER HORMONES? YES NO

ARE YOU PREGNANT? YES NO

EXPECTED DUE DATE _____________

	YES	NO
FAINTING SPELLS, SEIZURES OR EPILEPSY	O	O
DIABETES	O	O
TUBERCULOSIS/OTHER RESPIRATORY DISEASE	O	O
CANCER/TUMOR	O	O
GLAUCOMA	O	O
HEPATITIS, JAUNDICE OR LIVER TROUBLE	O	O
HERPES	O	O
HIV POSITIVE/AIDS	O	O
HAVE YOU BEEN HOSPITILIZED IN THE LAST 5 YRS?	O	O
DO YOU HAVE ANY DISEASE, PROBLEM OR CONDITION NOT LISTED? ___________________	O	O
DO YOU HAVE PSYCHIATRIC PROBLEMS?	O	O
DURING THE PAST MONTH HAVE YOU TAKE ANY OF THE FOLLOWING?		
OSTEOPOROSIS MEDICINE	O	O
BONE STRENGTHENING MEDICINE	O	O
ANTIBIOTICS OR SULFA DRUGS	O	O
ANTICOAGULANTS (e.g. COUMADIN)	O	O
HIGH BLOOD PRESSURE MEDICINE	O	O
TRANQUILIZER	O	O
INSULIN, ORINASE OR SIMILAR DRUG	O	O
ASPIRIN (DAILY)	O	O
DIGITALIS OR DRUGS FOR HEART TROUBLE	O	O
NITROGLYCERINE	O	O
ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING?		
LOCAL ANESTHETICS ('NOVOCAINE')	O	O
PENICILLIN OR OTHER ANTIBIOTICS	O	O
SULFA DRUGS	O	O
ASPIRIN	O	O
CODEINE	O	O
OTHER _____________________________________		

LIST MEDICATIONS YOU TAKE EVERY DAY: ____

____

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SIGNATURE ____ **DATE** __________________________