	Name			MEDICAL HISTORY						
atient	Account No.				Medical Alert					
1.	Physician's Name									
	Have you had any medical care w	vithin th	ne past t	two years?					Yes	No
2.	Have you taken any medication or drugs during the past two years?								Yes	No
	If yes, please list name and dosag	ge								
3.	Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?									No
	If yes, please list name and dosage									
4.	Have you ever taken bone loss pr		on drugs	s such as Fosamax,	Actonel, Boniva	a or oth	er bispho	osphonates?	Yes	No
	If yes, please list name and dosag									
5.	Are you aware of having an allerg If yes, please specify			reaction to any sub	ostance or medi	cation?			Yes	No
6	Have you been a patient in the ho			no pact five years?					Voc	No
	Indicate which of the following yo								103	140
	molecule willow of the following yo	u navo	ridu, oi	navo at prosont. O	mole yes of th	0 10 00	aon nom.			
	Heart (Surgery, Disease, Attack)	Yes	No	Ulcers			No	Hepatitis A B C (circle)		No
	Chest Pain	Yes	No	Diabetes			No	Venereal Disease		No
	Congenital Heart Disease	Yes	No	Thyroid Problems			No	A.I.D.S./H.I.V. Positive		No
	Heart Murmur	Yes	No	Glaucoma			No	Cold Sores/Fever Blisters		No
	High/Low Blood Pressure Mitral Valve Prolapse	Yes	No No	Contact lenses Emphysema			No No	Blood Transfusion		No No
	Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough			No	Sickle Cell Disease		No
	Rheumatic Fever	Yes	No	Tuberculosis			No	Bruise Easily		No
	Arthritis/Rheumatism	Yes	No	Asthma			No	Liver Disease/Yellow Jaundice		No
	Cortisone Medicine	Yes	No	Hay Fever/Allergy			No	Neurological Disorders		No
	Swollen Ankles	Yes	No	Latex Sensitivity			No	Epilepsy or Seizures		No
	Stroke	Yes	No	Sinus Trouble		Yes	No	Fainting or Dizzy Spells		No
	Diet (Special/Restricted)	Yes	No	Radiation Therapy	у	Yes	No	Nervous/Anxious	. Yes	No
	Artificial Joints (hip, knee, etc.)		No	Chemotherapy			No	Psychiatric/Psychological Care.		No
	Kidney Trouble	Yes	No	Tumors		Yes	No	Cancer	. Yes	No
8.	Have you lost or gained more tha	n 10 pc	ounds in	the past year?					Yes	No
	Do you have or have you had any									No
	If yes, please list:				or notour amount					
10.	Women: Are you pregnant or to				es Me	onths	No	Nursing? Yes No		
	Do you use birth control prescript									No
l a a	understand the above infor inswered all questions to the lisk the respective health call any change in my health or r	matio e bes re pro	n is ne t of my	ecessary to prov y knowledge. St	vide me with hould further	denta inforn	l care in	n a safe and efficient mann be needed, you have my p	ner. I ha	ave
	stiant/Consilian Cianatura									
Pa	atient/Guardian Signature					-		Date		