

MEDICAL HISTORY UPDATE

Do you have any new/changed medical conditions?

Name of your primary care specialist and physicians.

Please list any current medication that you are taking, including over the counter.

Do you have any allergies?

antibiotics ____, other medications ____, metal ____, food ____, other ____.

If yes, please list.

Have you had any recent hospital stays or surgery?

If yes, please list.

Have you had joint replacement? Chemotherapy?

Pacemaker? Heart valve problem?

If yes, please list.

Do you need to pre-medicate?

Signature

Date