

Please indicate the following which you have had, or have at present. Circle "Yes" or "No" to each item.

Heart (surgery, disease, attack)	Yes	No	Hemophilia	Yes	No
Chest Pain	Yes	No	Sickle Cell Disease	Yes	No
Congenital Heart Disease	Yes	No	Bruise Easily	Yes	No
Heart Murmur	Yes	No	Liver Disease	Yes	No
High Blood Pressure	Yes	No	Yellow Jaundice	Yes	No
Mitral Valve Prolapse	Yes	No	Neurological Disorders	Yes	No
Artificial Heart Valve	Yes	No	Epilepsy or Seizures	Yes	No
Heart Pacemaker	Yes	No	Nervous / Anxious	Yes	No
Rheumatic Fever	Yes	No	Smoke	Yes	No
Artificial Joints (hip,knee,etc)	Yes	No	Use Alcohol	Yes	No
			Psychiatric / Psychological Care	Yes	No
Arthritis / Rheumatism	Yes	No	Drug Addiction	Yes	No
Cortisone Medicine	Yes	No			

Any other disease or condition? _____

Are you taking any medications? Yes No
If so, Please Llist: _____

Are you allergic to any medications? Yes No
If so, Please List: _____

When was the last time you saw your medical Dr ?

Physician's Name: _____
Telephone #: _____

Hepatitis (B, C)	Yes	No
Venereal Disease	Yes	No
Herpes	Yes	No
Cold Sores / Fever Blisters	Yes	No
H.I.V. Positive	Yes	No
AIDS	Yes	No
Blood Transfusion	Yes	No

Women:	Pregnant?	Yes	No
	Nursing?	Yes	No
	BC Pills?	Yes	No
Do you take any of the following?			
	Fosamax	Yes	No
	Aredia	Yes	No
	Zometa	Yes	No
	Bonefos	Yes	No

PATIENT'S SIGNATURE: _____ DATE: _____

Staff Member's Signature: _____ Date: _____