Medical History:

Physician: _____ Phone Number _____

Please Check if you've had any of the following and date of surgery:

____ Knee, Hip, or any other joint replacement

____ Pacemaker

____ Heart Surgery **Do you require pre medication? _____**

Please list any other recent surgeries or hospitalizations _____

_____

Women: Are you pregnant or nursing? _____ Taking birth control? _____

Please check if you have had any of the following:

__Anemia
__Arthritis/rheumatism
__Asthma
__Abnormal bleeding
__Blood Disease
__Cancer
__Diabetes
__Drug dependency
__Epilepsy
__Glaucoma
__Heart Murmur
__Heart problems
__Hepatitis
__High blood pressure
__HIV/AIDS
__Kidney Disease
__Liver Disease
__Mitral valve prolapse
__Radiation treatment
__Stroke
__Tobacco use
__Tuberculosis
__ Other _____

Please list any current medications:

_____

Please list any allergies you might have:

_____

Have you ever taken Bisphosphonates? ____

To the best of my knowledge, the information is complete and correct. I understand it is my responsibility to inform the doctor if I or my minor child has had a change in health.

Patient or Guardian signature _____Date _____Dr initials____

Update_____Date_____Dr Initials_____

Update_____Date_____Dr initials_____