MEDICAL HISTORY

	YES	NO
1. Have you been a patient in the hospital during the past two years?	( )	( )
2. Have you been under the care of a medical doctor during the past two years?	( )	( )
Physician's Name _____		
Phone number _____		
3. Are you now taking any medication, pills, or drugs?_____	( )	( )
If yes, please list: _____		
_____		

4. Are you allergic or have you reacted adversely to any of the following medications?

( ) Aspirin	( ) Nitrous Oxide	( ) Valium	( ) Novacaine
( ) Darvon	( ) Erythromycin	( ) Scopolamine	( ) Xylocaine
( ) Codeine	( ) Tetracycline	( ) Penicillin	( ) Demerol
( ) Percodan	( ) Other Antibiotics	( ) Sulfa	

5. Are you aware of being allergic to any other medications or substances? YES _____ NO ____
6. Check any of the following which you have had or have at present:

( ) Heart Failure	( ) Emphysema	( ) AIDS / HIV
( ) Heart Disease or Attack	( ) Cough	( ) Hepatitis A (infectious)
( ) Angina Pectoris	( ) Tuberculosis (TB)	( ) Hepatitis B (serum)
( ) High Blood Pressure	( ) Asthma	( ) Liver Disease
( ) Heart Murmur	( ) Hay Fever	( ) Yellow Jaundice
( ) Rheumatic Fever	( ) Sinus Trouble	( ) Blood Transfusion
( ) Congenital Heart Lesions	( ) Allergies or Hives	( ) Drug Addiction
( ) Scarlet Fever	( ) Diabetes	( ) Hemophilia
( ) Artificial Heart Valve	( ) Thyroid Disease	( ) Venereal Disease
( ) Heart Pacemaker	( ) X-Ray or Cobalt Treatment	( ) Cold Sores
( ) Heart Surgery	( ) Fever Blisters	( ) Chemotherapy (Cancer)
( ) Artificial Joints (Hip, Knee)	( ) Arthritis	( ) Epilepsy or Seizures
( ) Anemia	( ) Rheumatism	( ) Fainting or Dizzy Spells
( ) Stroke	( ) Cortisone medicine	( ) Nervousness
( ) Kidney Trouble	( ) Glaucoma	( ) Psychiatric Treatment
( ) Ulcers	( ) Pain in Jaw Joints	( ) Sickle Cell Disease
( ) Cosmetic Surgery	( ) Tobacco Habit	( ) Bruise Easily

7. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are tired? YES _____ NO _____
8. Do your ankles swell during the day? YES _____ NO _____
9. Do you use more than two pillows to sleep? YES ____ NO __
10. Has your medical doctor ever said you have cancer or tumor? YES ____ NO ____
11. Please list any disease, condition or problem you have not noted above: _____
_____

WOMEN:

Are you pregnant? YES____ NO ____
Are you taking birth control pills: YES ____ NO____
Have you ever taken IV Bisphosphonates? YES____ NO_____

In case of emergency, whom may we contact?

Name: _____ Relationship to Patient _____
Phone Number _____

Please check the method of payment most convenient for you to use:

PAYMENT AT THE END OF EACH VISIT (CASH OR CHECK) _____
BANK CHARGE CARD (VISA, MASTER CARD, AMERICAN EXPRESS OR DISCOVER) _____

SIGNATURE _____