Please be very accurate in the following sections. The confidentiality of this medical record is assured.

Are you in good general health? ❑ Yes ❑ No List any illness or disease that you have been treated for in the last two years: ____________________________. List any prescription medications: ____

List any over-the-counter, natural or homeopathic medications: ____

List any known allergies: ____ List any recreational drugs used: ______________________________________

Doctor's name & phone____

Are you allergic to latex? ………………………………… ❑ Yes ❑ No

Have you ever had heart problems?……………………… ❑ Yes ❑ No

Have you ever had a heart attack? ……………………… ❑ Yes ❑ No

Have you ever been told that you have a heart murmur? … ❑ Yes ❑ No

Do you have an artificial heart valve? …………………… ❑ Yes ❑ No

Have you had a heart infection? ………………………… ❑ Yes ❑ No

Have you ever been told that you have a heart defect or congenital heart problems? …………………………… ❑ Yes ❑ No

Do you get chest pain or angina? ……………………….. ❑ Yes ❑ No

Do you have jaw joint problems or a history of TMJ? ……… ❑ Yes ❑ No

Do your ankles swell? ……………………………………… ❑ Yes ❑ No

Women: Are you pregnant or nursing? …………………… ❑ Yes ❑ No

Do you have difficulty breathing or shortness of breath? …… ❑ Yes ❑ No

Have you ever had asthma attacks? ……………………… ❑ Yes ❑ No

Do you have a cough? …………………………………… ❑ Yes ❑ No

Do you drink alcoholic beverages? ……………………….. ❑ Yes ❑ No

How much do you smoke?.........❑ None ❑ 1 pack/day ❑ 2 packs/day ❑ More

Have you ever had hepatitis? ……………………………… ❑ Yes ❑ No

Do you have HIV/AIDS, or have you been exposed to AIDS? ❑ Yes ❑ No

Do you have problems with ulcers? ……………………… ❑ Yes ❑ No

Do you have digestive problems……………………….… ❑ Yes ❑ No

Do you have difficulty urinating? ……………………… ❑ Yes ❑ No

Do you urinate more than six times each day? ………….. ❑ Yes ❑ No

Are you diabetic? ……………………………………… . ❑ Yes ❑ No

Have you ever had seizures or convulsions? …………….. ❑ Yes ❑ No

Have you ever had a stroke? ……………………………. ❑ Yes ❑ No

Do you get cold sores…………………………………… ❑ Yes ❑ No

Do you have any bleeding problems? ……………... ……… ❑ Yes ❑ No

Have you been anemic recently? ……………….………. ❑ Yes ❑ No

Have you ever had cancer or radiation therapy? ……….. ❑ Yes ❑ No

Do you have prosthetic or artificial joints? ……………....… ❑ Yes ❑ No

Have you in the past taken, or are you currently taking any medication for osteoporosis?..…………………………………………… ❑ Yes ❑ No

THIS INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE:

Signature of Patient **Date**

Print Name