## Medical History

Today's Date: _____

Patient Name (Last, First, Initial): _____DOB:_____

Primary Physician's Name & Phone Number: _____

Please circle **YES** or **NO** for the following questions:

Are you under your physician's care at this time for an ongoing condition?.....Yes No

If so since when? _____ What for? _____

Do you take any medications or substances including vitamins, herbal supplements etc.? .....Yes No

If yes, please list (use back of form if necessary)_____

Do you have any drug allergies or problems with any drugs, substances or anesthetics?.....Yes No

If Yes to what and what was the reaction? _____

Do you have any sensitivity to metals or latex?.....Yes No

Are you pregnant or suspect you may be pregnant?.....Yes No

Have you ever been diagnosed or treated for heart disease?.....Yes No

Do you have a pacemaker, an artificial heart valve implant or diagnosed with mitral valve prolapse?.....Yes No

Have you ever had rheumatic fever?.....Yes No Do you have a heart murmur?.....Yes No

Do you have High or Low blood pressure? (If yes circle which one).....Yes No

Have you ever had radiation treatment or chemo treatment for any condition?.....Yes No

Have you ever taken any oral or IV treatment of bisphosphonates (Fosamax, Zometa, Aredia, etc.).....Yes No

Do you have arthritis, rheumatism or any other inflammatory disease?.....Yes No

Do you have any artificial prosthesis or joints? (If yes, what date replaced?)_____Yes No

Do you have any blood disorders such as leukemia, anemia, etc.?.....Yes No

Have you ever had a problem with excessive bleeding after being cut or injured?.....Yes No

Do you have any stomach, liver or kidney problems? (If yes circle which one).....Yes No

Are you diabetic?.....Yes No

Do you have epilepsy, seizures, fainting or dizzy spells? (If yes circle which one).....Yes No

Do you have asthma?.....Yes No

Have you tested HIV positive or have AIDS?.....Yes No

Have you had or do you have Hepatitis?.....Yes No

Do you or have you tested positive for T.B.?.....Yes No

Do you smoke or use tobacco? If yes, how much and how often?_____ Yes No

Do you habitually use controlled substances?.....Yes No

Do you have any other disease, condition or problem not listed? If so, please explain_____

Is there anything else we should know about your health not covered yet?_____

Is there anything regarding your health that you would like to speak to Dr. Broadbent in private about? Yes No

**Additional Information**

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient's / Guardian's Signature_____ Date_____

ANEST.

MED. ALERT

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