TIME 10:43 AM DATE 7/12/2011

MEDICAL HISTORY

Other If yes, please explain: Do you have, or have you had, any of the following? AlDS/HIV Positive	PATIENT NAME		Birth Date		
lave you verb een hospitalized or had a major operation? Yes No If yes, please explain: Have you verb and a serious head or neck injury? Yes No No If yes, please explain:	have, or medication that you may b				
Very No No Nursing? Yes Nursing?	lave you ever been hospitalized or ha Have you ever had a serious Are you taking any medica Do you take, or have you taken, Have you ever taken Fosamax, E other medications containi Are y	ad a major operation? Yes Need or neck injury? Yes Need or neck injury. Actonel or any neg bisphosphonates? Yes Need or neck injury.	If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain:		
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs Other If yes, please explain: Do you have, or have you had, any of the following? AlbSrHIV Positive Yes No Cortisone Medicine Yes No Hepatitis A Yes No Recent Weight Loss Yes No Anaphysias Yes No Drug Addiction Yes No Hepatitis B or C Yes No Remail Dialysis Yes No Anaphysias Yes No Anaphysias Yes No Anternia Yes No Easily Winded Yes No Herpatitis B or C Yes No Remail Dialysis Yes No Antificial Hard Valve Yes No Affidial Joint Yes No No Affidial Joint Yes No No Blood Disease Yes No Robert Diarrhes Yes No Robert D	Women: Are you				
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs	Pregnant/Trying to get pregnant?	Yes No Taking oral conti	raceptives? Yes No	Nursing? O Yes No	
AlDs/HIV Positive	Aspirin Penicillin		hetics Acrylic	Metal Latex	Sulfa drugs
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be	AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anemia Yes No Angina Yes No Arthritis/Gout Yes No Artificial Heart Valve Yes No Artificial Joint Yes No Asthma Yes No Blood Disease Yes No Blood Transfusion Yes No Breathing Problem Yes No Bruise Easily Yes No Cancer Yes No Chemotherapy Yes No Chest Pains Yes No Cold Sores/Fever Blisters Yes No Conyulsions Yes No	Cortisone Medicine Yes Diabetes Yes Drug Addiction Yes Easily Winded Yes Emphysema Yes Epilepsy or Seizures Yes Excessive Bleeding Yes Excessive Thirst Yes Excessive Thirst Yes Frequent Cough Yes Frequent Diarrhea Yes Genital Herpes Yes Glaucoma Yes Hay Fever Yes Heart Attack/Failure Yes Heart Pacemaker Yes Heart Trouble/Disease Yes Greatly Frequent Pierre Yes Heart Trouble/Disease Yes Greatly Frequent Heart Trouble/Disease Yes Greatly Frequent Heart Trouble/Disease Yes Greatly Frequent Yes Greatly Frequent Yes Greatly Frequent Yes Greatly Frequent Heart Murmur Yes Greatly Frequent Heart Trouble/Disease Yes Greatly Frequent Yes Greatly Frequent Heart Trouble/Disease Yes Greatly Frequent Yes Greatly Frequent Heart Trouble/Disease Yes Greatly Frequent Heart Trouble/Disease	No Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No High Cholesterol Yes No High Cholesterol Yes No Hives or Rash Yes No Hypoglycemia Yes Irregular Heartbeat Yes Kidney Problems Yes Leukemia Yes Low Blood Pressure Yes Lung Disease Yes Mo No Mitral Valve Prolapse Yes No No Pain in Jaw Joints Yes No Parathyroid Disease Yes No Psychiatric Care Yes	Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles No Sickle Cell Disease No Sinus Trouble Spina Bifida Stomach/Intestinal Dis No Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease	Yes N.
	Comments:				
					nation can be