## **MEDICAL HISTORY**

Alzheimer's Disease	PATIENT NAME		Birth Date	
lave you ever been hospitalized or had a major operation? Yes   No   Have you ever had a serious head or neck injury? Yes   No   Do you take, or have you taken, Phen-Fen or Redux? Yes   No   Have you ever taken Fosams, Convex, Actorie of any yes   No   Have you ever taken Fosams, Convex, Actorie of any yes   No   Obyou use tobacco? Yes   No   Do you use tobacco? Yes   No   PregnantTrying to get pregnant?   Ves   No   Taking oral contraceptives? Yes   No   Nursing? Yes   No   Women: Are you.  PregnantTrying to get pregnant?   Ves   No   Taking oral contraceptives? Yes   No   Nursing? Yes   No   Women: Are you and special del? Yes   No   PregnantTrying to get pregnant?   Ves   No   Taking oral contraceptives? Yes   No   Nursing? Yes   No   Women: Are you allargic to any of the following?    Other If yes, please explain:	have, or medication that you may be			
Pregnant/Trying to get pregnant?	Have you ever been hospitalized or had Have you ever had a serious h Are you taking any medicati Do you take, or have you taken, F Have you ever taken Fosamax, Bo other medications containin Are yo Do you use cor	d a major operation? Yes No nead or neck injury? Yes No ons, pills, or drugs? Yes No when-Fen or Redux? Yes No niva, Actonel or any g bisphosphonates? Yes No u on a special diet? Yes No oyou use tobacco? Yes No	If yes, please explain:  If yes, please explain:	
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs Other If yes, please explain:	_	Yes No Taking oral contract	eptives? Yes No Nursing	ı? ○ Yes ○ No
AIDS/HIV Positive	Aspirin Penicillin	_	ics Acrylic Meta	ıl
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           Chest Pains         Yes         No           Cold Sores/Fever Blisters         Yes         No           Congenital Heart Disorder         Yes         No           Convulsions         Yes         No	Cortisone Medicine Yes No Diabetes Yes No Prug Addiction Yes No Easily Winded Yes No Emphysema Yes No Excessive Bleeding Yes No Excessive Thirst Yes No Frequent Cough Yes No Frequent Diarrhea Yes No Frequent Headaches Yes No Genital Herpes Yes No Glaucoma Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Pacemaker Yes No Heart Pacemaker Yes No Heart Trouble/Disease No No No 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 Hives or Rash Yes No Hypoglycemia Yes No Kidney Problems Yes No Leukemia Yes No Leukemia Yes No Low Blood Pressure Yes No Low Blood Pressure Yes No Mitral Valve Prolapse Yes No O Steoporosis Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No	Recent Weight Loss Yes No Renal Dialysis Yes No Rheumatic Fever Yes No Rheumatism Yes No Scarlet Fever Yes No Sickle Cell Disease Yes No Sinus Trouble Yes No Stomach/Intestinal Disease Yes No Stroke Yes No Swelling of Limbs Yes No Thyroid Disease Yes No Tonsillitis Yes No Tumors or Growths Yes No Venereal Disease Yes No Ves No Ve
	Comments:			
SIGNATURE OF PATIENT, PARENT, or GUARDIAN	dangerous to my (or patient's) health	n. It is my responsibility to inform the		cal status.