

### Dr. Farzam Maleki - Medical History Form

Patient Name:

Birth Date:

Date Created:

Are you under a physician's care now?  Yes  No If yes

Name and number of Physician  If yes

Have you ever been hospitalized or had a major operation in the past two years?  Yes  No If yes

Are you taking any medications, pills, or drugs?  Yes  No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? List and Date  Yes  No If yes

Do you have Artificial Joint? Please list and date  Yes  No If yes

Do you smoke/chew tobacco? if yes, how many cigarettes/packs a day?  Yes  No If yes

**WOMEN: Are you...**

Pregnant/Trying to get pregnant?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Metal

Latex  Sulfa Drugs  Local Anesthetics  Acrylic

Other?  Yes  No If yes

Drug addiction or Alcohol/ chemical dependency  Yes  No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Arthritis <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No
Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No	Kidney Disease <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No
Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No
Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No
Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No
Dementia <input type="radio"/> Yes <input type="radio"/> No	Acid Reflux/GERD <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B <input type="radio"/> Yes <input type="radio"/> No	Hepatitis C <input type="radio"/> Yes <input type="radio"/> No
Infective Endocarditis <input type="radio"/> Yes <input type="radio"/> No	Bleeding Disorders <input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea <input type="radio"/> Yes <input type="radio"/> No	

Have you ever had any serious illness not listed above?  Yes  No If yes

Comments:

Signature \_\_\_\_\_ Date \_\_\_\_\_