

# MEDICAL INFORMATION

Patient Name \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_

Hgt \_\_\_\_\_ Wgt \_\_\_\_\_ lbs Pulse \_\_\_\_\_ B/P \_\_\_\_\_

Allergies \_\_\_\_\_

- Latex  Sulfa  Local Anesthetics

Smoke Tobacco?  Yes  No  Packs/day \_\_\_\_\_ Number of Years \_\_\_\_\_

Have you ever had a Pelvic, Hip or Leg fracture?.....  Yes  No

If yes what/when? \_\_\_\_\_

Have you had surgery within the last six months? .....  Yes  No

If yes what surgery? \_\_\_\_\_

Ever had  Hysterectomy  Heart Surgery  Angiogram

Do you require antibiotics before surgery or dental work?..  Yes  No

Do you get short of Breath walking up one flight of stairs?  Yes  No

Are you now or have you ever been treated for any of the Medical conditions listed below? (Please check all that apply)

- |  |                                    |                                    |                                      |
|--|------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Heart Disaese       | <input type="checkbox"/> Cancer    | <input type="checkbox"/> Lupus     | <input type="checkbox"/> Asthma/COPD |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Seizure   | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Stroke      |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psoriasis |                                      |

Are you currently taking any of the Medications Listed below? (Please check all that apply)

- |                                   |                                   |                                     |                                 |                                 |
|-----------------------------------|-----------------------------------|-------------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> Coumadin | <input type="checkbox"/> Aspirin  | <input type="checkbox"/> Insulin    | <input type="checkbox"/> Requip | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Plavix   | <input type="checkbox"/> Dilantin | <input type="checkbox"/> Prednisone | <input type="checkbox"/> Valium | <input type="checkbox"/> Xanax  |
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