

Drs. Sugarman and Brunner, LLC
MEDICAL HISTORY QUESTIONNAIRE

Are you under the care of a physician other than your routine care physician? List specialty: _____ Yes No

Please list any prescribed medications that you are taking, including any over-the-counter drugs, vitamins, herbs, and inhalers:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Are you allergic to any medications? Yes No

Please list:

Do you take any of these medications?

Daily Aspirin Effient Coumadin Plavix Persantine Ticlid Aggrenox Pletal

Do you have diabetes? HbA1c: _____ Yes No

Have you ever been told you have high or low blood pressure? Yes No

Have you ever had any heart ailments? Yes No

Please identify:

Have you ever had: rheumatic fever rheumatic heart disease a heart murmur? No

Have you ever had: hip knee other joint replacement? When? _____ No

Have you been told to **premedicate** with antibiotics for dental procedures? Yes No

Have you ever had kidney or bladder problems? Yes No

Have you ever had any liver problems or hepatitis? Yes No

Are you HIV+ or do you have AIDS? Yes No

Have you ever had excessive bleeding, anemia, or any blood problems? Yes No

Have you had breathing problems, asthma, emphysema, or TB? Yes No

Are you pregnant? Yes No

Do you smoke cigarettes? Yes No How many per day? _____ Do you use other tobacco products? Yes No

Do you drink alcoholic beverages? How many per week? _____ Yes No

Do you have Osteoporosis or Osteopenia? Yes No

Do you now, or have you ever taken bisphosphonates? When?

Fosamax Boniva Zometa Actonel

Reclast Aredia Other: _____ No

Have you ever had major surgery or been hospitalized? Please list and include dates. Yes No

1. _____ 3. _____

2. _____ 4. _____

Please list any other conditions you feel we need to know:

I understand that providing incorrect information can be dangerous to my health, therefore, the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

Name (Print):

Signature:

Date: