MEDICATIONS

ARE YOU NOW TAKING ANY KIND OF MEDICINE, DRUG OR PILLS FOR ANY PURPOSE?

	YES	NO
Anticoagulants?		
Tranquilizers?		
Cortisone?		
Insulin?		
Blood pressure medicine?		
Any other medicines?		

Osteoporosis medicines? _____

ARE YOU ALLERGIC TO OR HAD A REACTION TO?

	YES	NO
Local Anesthetics?		
Penicillin?		
Sulfa drugs?		
Other Antibiotics?		
Barbiturates, sedatives or sleeping pills?		
Aspirin?		
Iodine?		
Codeine or other narcotics?		
Other medications?		
Allergies other than drug allergies? (*Please list*) Latex?		

_____

_____

IS THERE ANY CONDITION CONCERNING YOUR HEALTH OR FAMILY'S ANESTHETIC HISTORY THAT THE DOCTOR SHOULD BE TOLD?

	YES	NO
WOMEN: Is there a possibility that you may be pregnant?		
Estimated delivery date:		
Are you nursing?		
Are you taking birth control pills?		

_____

_____

WOMEN NOTE: Antibiotics (such as penicillin, erythromycin, etc.) and some pain medications may alter the effectiveness of birth control pills. Consult you physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature: _____ Date: _____ Patient's Signature: _____ Date _____

Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Acknowledgement of receipt of Notice of Privacy Practices

I, _____(print), have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature Date

Print Clear Form