

MEDICATIONS

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

Anticoagulants?
 Tranquilizers?
 Cortisone?
 Insulin?
 Blood pressure medicine?
 Any other medicines?

 Osteoporosis medicines? _____

YES	NO

ARE YOU ALLERGIC TO OR HAD A REACTION TO?

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?

YES	NO

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

WOMEN: Is there a possibility that you may be pregnant?
 Estimated delivery date:
 Are you nursing?
 Are you taking birth control pills?

YES	NO

WOMEN NOTE: Antibiotics (such as penicillin, erythromycin, etc.) and some pain medications may alter the effectiveness of birth control pills. Consult your 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