HEALTH HISTORY

PATIENT NAME:	TODAY'S DATE: / /
SOCIAL SECURITY #:	DATE OF BIRTH: / /

HOME PHONE:	WORK PHONE:	CELL PHONE:

Have you had any of the following? PHYSICIAN'S NAME:

☐Allergies	☐Fibromyalgia	☐Low Blood Pressure
☐Anemia	☐Food Allergies	☐Lupus Erythematosus
☐Anorexia	☐Gastric Reflux	☐Medication Allergies
☐Anxiety	☐Glaucoma	☐Mitral Valve Prolapse
☐Arthritis	☐Growths	☐Neck Pain
☐Artificial Heart Valve	☐Headaches	☐Pacemaker
☐Artificial Joint	☐Head Injuries	☐Panic Attacks
☐Asthma	☐Hearing Loss	☐Respiratory Problems
☐Back Pain	☐Heart Attack	☐Rheumatic Fever
☐Blood Disease	☐Heart Disease	☐Rheumatoid Arthritis
☐Blood Transfusion	☐Heart Murmur	☐Seizures
☐Bulimia	☐Heartburn	☐Sinus Problems
☐Cancer	☐Hepatitis	☐Stomach Problems
☐Coronary Bypass	☐High Blood Pressure	☐Stroke or TIA
☐Diabetes	☐High Cholesterol	☐Thyroid Disease
☐Dizziness	☐HIV/AIDS	☐Tuberculosis
☐Epilepsy	☐Jaundice	☐Tumor
☐Excessive Bleeding	☐Kidney Disease	☐Ulcer
☐Fainting	☐Liver Disease	☐Other ______________

Do you:	Yes	No
Smoke	☐	☐
Use smokeless tobacco	☐	☐

BP:	
Pulse:	

Have you taken any of the following medications or therapies?

☐ Actonel	☐ I.V. Bisphosphonate
☐ Boniva	☐ Cortisone
☐ Fosamax	☐ Steroids
☐ Skelid	☐ Tetracycline
☐ Didronel	☐ Chemotherapy
☐ Reclast	☐ Radiation Therapy

☐ None of the above

Women: Are you pregnant or possibly pregnant? ☐ Yes ☐ No

I am allergic to the following medications:

I am allergic to the following foods:

Are you allergic to latex? ☐ Yes ☐ No

Medications you are taking:

Signature: Date:

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