## MEDICAL HISTORY

Patient Name: _____

Date of Birth:_____

Pharmacy Name: _____

Location: _____

1. Do you take blood thinner or daily aspirin? _____yes _____no
2. Have you ever had excessive bleeding? _____yes _____no
3. Do any family members have a bleeding disorder? _____yes _____no
4. Are you taking or have you ever taken these medications for osteoporosis or osteopenia:
   Actonel, Boniva, Fosamax, Reclast, Prolia ____yes _____no
5. Have you had chemotherapy for bone disease, breast cancer, prostate cancer, multiple myeloma, etc.? ____yes _____no
   If YES, have you taken any of the following: Zometa, Aredia, Avastin, XGeva _____yes _____no _____not sure
6. Are you, or have you been, in a drug or alcohol recovery program? _____yes _____no
7. Check yes or no on any of the following you have now or have had in the past:

| | | | |
|---|---|---|---|
| Heart Trouble | _____yes _____no | Jaundice | _____yes _____no |
| Congenital Heart Lesions | _____yes _____no | Fainting | _____yes _____no |
| Heart Murmur | _____yes _____no | Hepatitis | _____yes _____no |
| High Blood Pressure | _____yes _____no | Tuberculosis | _____yes _____no |
| Heart Valve Problems | _____yes _____no | Seizures | _____yes _____no |
| Rheumatic Fever | _____yes _____no | Epilepsy | _____yes _____no |
| Psychiatric Treatment | _____yes _____no | Asthma | _____yes _____no |
| Stroke | _____yes _____no | Diabetes | _____yes _____no |
| Joint Replacement | _____yes _____no | If Yes: Diet Control | _____ |
| Transplant Surgery | _____yes _____no | Tablets | _____ |
| | | Insulin Amount | _____ |

8. Do you have a primary care physician? _____yes _____no Doctor's name_____
9. Have you been under the care of a physician during the past 2 years? _____yes _____no
   Doctor's name____ _____ Dates_____
   Reason_____
10. Do you have any problems with your immune system or with healing? _____yes _____no
11. Do you have any problems with recurrent infections of any kind? _____yes _____no
12. What operations have you had in the past? PLEASE list with approximate dates.
    _____
    _____
13. Please list any medications you are currently taking including prescription, over the counter, herbal or holistic and vitamins.
    _____
    _____
14. Do you have any allergies (include ALL allergies): _____yes _____no
    Please list_____
15. Do you have any sensitivities to medication? _____yes _____no
    Please list_____
16. Any other information about your health that we should know about? _____yes _____no
    Please explain_____
17. Your approximate weight_____ height_____
18. Females: Is it possible that you are pregnant?_____ Are you nursing?_____
19. Do you smoke? _____yes [_____amt per day] _____no
    Have you smoked in the past? _____yes _____no
20. Do you wear contact lenses? _____yes _____no

**I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.**

_____ _____

Date Signature of person completing Health History/Legal Guardian (if patient is a minor)

Clinical Signature _____Date_____ Doctor Signature_____ Date_____

| BP: | P: | Temperature: |
|---|---|---|
| | | |