MEDICAL HISTORY

Reserved for Patient Identification Label

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 use drugs (including marijuana) or narcotics recreationally? _____ yes [_____how often?] _____no
21. 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: