Preferred Name: ____ Date: ______/______/20_____

Date of Birth:______/______/______

Medical History

1. Do you have (or have you ever had) any of the following?

Circle Below

Yes No a. allergic reaction to drugs or latex (Circle all that apply)
Latex Penicillin Aspirin Codeine Local Anesthetics Other:______________________

Yes No b. heart attack or heart disease

Yes No c. stroke

Yes No d. high blood pressure

Yes No e. congestive heart failure

Yes No f. angina (chest pains)

Yes No g. irregular heart beat

Yes No h. artificial heart valve

Yes No i. rheumatic fever, rheumatic heart disease

Yes No j. bacterial endocarditis (SBE)

Yes No k. congenital heart disease

Yes No l. heart murmur or mitral valve prolapse

Yes No m. Immunosuppressive condition (Circle all that apply)
Steroid Therapy (e.g. prednisone) Radiation Therapy Chemotherapy
SLE (Lupus) Rheumatoid Arthritis HIV Organ Transplant
Spleen Removed Other

Yes No n. artificial joint(s) (Circle all that apply)
Hip Knee Ankle Shoulder Other
Date(s) Placed:______________________

Yes No o. other artificial implants or devices

Yes No p. bleeding problem, anemia, other blood disease

Yes No q. diabetes

Yes No r. thyroid disease

Yes No s. nervous system disease or seizures

Yes No t. stomach or intestinal disease

Yes No u. kidney disease

Yes No v. hepatitis (A, B, C, or D)

Yes No w. other liver disease

Yes No x. arthritis (osteo or rheumatoid)

Yes No y. other muscle or joint disease

Yes No z. asthma

Yes No aa. tuberculosis

Yes No bb. other lung disease

Yes No 1. mental health condition – specify:______________________

Yes No 2. physical or mental disabilities that may require special care

Yes No 3. Do you have or have you ever been treated for cancer?

Yes No 4. Are you or could you be pregnant?

Yes No 5. Are you nursing?

Yes No 6. Do you have any disease, condition, or problem not listed here?
Describe:

Yes No 7. Have you ever been hospitalized or had surgery?
Describe:

Yes No 8. Do you have any undiagnosed symptoms?
Describe:

Yes No 9. Are you, or have you been addicted to a chemical substance?
(examples: alcohol, prescription drugs, heroin, meth, cocaine, other)

Yes No 10. Do you regularly take herbal medicines or dietary supplements?
Specifically, do you take (circle all that apply):
Echinacea Garlic Ginger Kava Valerian Feverfew
Gingko Ginseng St. John's Wort Vitamin E Other:____________

Yes No 11. Have you undergone current or past osteoporosis therapy?
(Examples are: Fosamax, Actonel, Boniva pill form)

Yes No 12. Have you undergone current or past bisphosphonate therapy?
(Examples: intravenous Aredia, Zometa)

Medications

Instructions for Patients: Enter all of the prescription and over-the-counter medications you are currently taking. Do **NOT** list dietary supplements or herbal medicines.

Name of medication	Dosage	Times taken per day	What is it taken for?	Date medication started