HEALTH HISTORY

PATIENT NAME: _____

PHYSICIAN'S NAME: _____ DATE OF LAST VISIT: _____

HAVE YOU EVER USED A BIPHOSPHONATE MEDICATION? COMMON BRAND NAMES ARE FOSAMAX, ACETONEL, ATELVIA, DIDRONEL BONIVA? **YES/NO**

HAVE YOU EVER TAKEN ANY OF THE GROUP DRUGS COLLECTIVELY REFFERED TO AS "FEN-PHEN"? THESE INCLUDE COMBINATIONS OF LONIMIN, ADIPEX, FASTIN (BRAND NAMES OF PHENTERMINE). PONDIMIN (FENFLURAMINE) AND REDUX (DEXFENFLURAMINE). **YES/ NO**

PLEASE CIRCLE "**YES**" OR "**NO**" TO INDICATE IF YOU HAD ANY OF THE FOLLOWING:

AIDS/HIV	**YES/NO**	EPILEPSY	**YES/NO**	RADIATION TREATMENT	**YES/NO**
ANEMIA	**YES/NO**	FAINTING OR DIZZINESS	**YES/NO**	RESPIRATORY DISEASE	**YES/NO**
ARTHRITIS, RHEUMATISM	**YES/NO**	GLAUCOMA	**YES/NO**	RHEUMATIC FEVER	**YES/NO**
ARTIFICIAL HEART VALVES	**YES/NO**	HEADACHES	**YES/NO**	SCARLET FEVER	**YES/NO**
ARTIFICIAL JOINTS	**YES/NO**	HEART MURMUR	**YES/NO**	SHORTNESS OF BREATH	**YES/NO**
ASTHMA	**YES/NO**	HEART PROBLEMS	**YES/NO**	SINUS TROUBLE	**YES/NO**
BACK PROBLEMS	**YES/NO**	HEPITIS TYPE ____	**YES/NO**	SKIN RASH	**YES/NO**
BLEEDING ABNORMALL, WITH EXTRACTIONS OR SURGERY	**YES/NO**	HERPES	**YES/NO**	SPECIAL DIET	**YES/NO**
BLOOD DISEASE	**YES/NO**	HIGH BLOOD PRESSURE	**YES/NO**	STROKE	**YES/NO**
CANCER	**YES/NO**	JAUNDICE	**YES/NO**	SWOLLEN FEET OR ANKLES	**YES/NO**
CHEMICAL DEPENDENCY	**YES/NO**	JAW PAIN	**YES/NO**	SWOLLEN NECK GLANDS	**YES/NO**
CHEMOTHERAPY	**YES/NO**	KIDNEY DISEASE	**YES/NO**	THYROID PROBLEMS	**YES/NO**
CIRCULATORY PROBLEMS	**YES/NO**	LIVER DISEASE	**YES/NO**	TONSILITIS	**YES/NO**
CONGENITAL HEART LESIONS	**YES/NO**	LOW BLOOD PRESSURE	**YES/NO**	TUBERCULOSIS	**YES/NO**
CORTISONE TREATMENTS	**YES/NO**	MITRAL VALVE PROLAPSE	**YES/NO**	TUMOR OR GROWTH ON HEAD OR NECK	**YES/NO**
COUGH, PERSITENT OR BLOODY	**YES/NO**	NERVOUS PROBLEMS	**YES/NO**	ULCER	**YES/NO**
DIABETES	**YES/NO**	PACEMAKER	**YES/NO**	VENEREAL DISEASE	**YES/NO**
EMPHYSEMA	**YES/NO**	PSYCHIATRIC CARE	**YES/NO**	WEIGHT LOSS, UNEXPLAINED	**YES/NO**

WOMEN:

ARE YOU PREGNANT? **YES/NO** DUE DATE: _____ TAKING BIRTH CONTROL PILLS? **YES/NO** ARE YOU NURSING? **YES/NO**

MEDICATIONS:

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING AND THE CORRELATING DIAGNOSIS:

_____

_____

_____

_____

_____

ARE YOU TAKING ANY BLOOD THINNERS (ASPIRIN, PLAVIX, COUMADIN, ETC.)? PLEASE LIST.

_____

_____

PHARMACY NAME: _____

PHONE (_____) _____

ALLERGIES:

- ☐ ASPIRIN
- ☐ BARBITURATES (SLEEPING PILLS)
- ☐ LOCAL ANESTHESIA
- ☐ PENICILLIN
- ☐ LATEX
- ☐ IODINE
- ☐ CODEINE
- ☐ SULFA
- ☐ OTHER: _____

_____

_____