

**HEALTH HISTORY FOR:** \_\_\_\_\_

Yes No **Are you currently under a physician's care? If so, why?** \_\_\_\_\_  
\_\_\_\_\_

Physician's name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Yes No **Are you taking any medications or health related substances?  
If so, please list what you take and why.**

Medication \_\_\_\_\_ For \_\_\_\_\_  
Medication \_\_\_\_\_ For \_\_\_\_\_  
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Medication \_\_\_\_\_ For \_\_\_\_\_  
Medication \_\_\_\_\_ For \_\_\_\_\_  
Medication \_\_\_\_\_ For \_\_\_\_\_

Yes No **Are you allergic to any medications, latex, or other substances? If so, what?** \_\_\_\_\_  
\_\_\_\_\_

**Do you have or have you ever had:**

Yes No Asthma or other respiratory difficulties	Yes No Artificial joints, implants, or prosthesis
Yes No Rheumatic fever	Yes No Stomach problems
Yes No Heart murmurs	Yes No Kidney or liver problems
Yes No High blood pressure	Yes No Diabetes
Yes No Pacemaker or artificial heart valves	Yes No Epilepsy or seizure disorders
Yes No Other heart disease	Yes No Positive HIV test or AIDS
Yes No Blood disorders, anemia, leukemia	Yes No Hepatitis
Yes No Do you bleed excessively	Yes No Tuberculosis
Yes No Radiation treatment to your head or neck	Yes No Drug or alcohol addiction
Yes No Arthritis or rheumatism	Yes No Psychiatric treatment

Yes No Do you smoke or use any other forms of tobacco? \_\_\_\_\_  
If so, what and how often?

Yes No Have you taken oral Bisphosphonate drugs such as but not limited to: Actonel, Boniva, Didronel, Fosamax, Fosamax Plus D, Skelid?

Yes No Have you taken IV Bisphosphonate drugs such as but not limited to: Aredia, Zometa?

**Women:**

Yes No Are you pregnant?

Yes No Do you use birth control medication?

Yes No If so, have you been counseled about possible antibiotic interactions?

**Is there anything else we should know about your health? If so, please explain:** \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_