

HEALTH HISTORY

ARE YOU UNDER A PHYSICIAN'S CARE? YES _____ NO _____

IF (YES) REASON _____

PHYSICIAN'S NAME _____ PHONE _____

DATE OF LAST PHYSICAL? DATE ____/____/____

HAVE YOU EVER HAD A SERIOUS ILLNESS OR OPERATION? YES _____ NO _____

IF (YES) EXPLAIN _____

HAVE YOU EVER TAKEN ANY BONE DRUGS? (CIRCLE ALL THAT APPLY): FOSAMAX EVISTA BONIVA
BONEFOS ACTONEL DIDRONEL FORTEO SKELID AREDIA ZOMETA RECLAST OTHERS?

ARE YOU TAKING ANY OTHER MEDICATIONS? YES _____ NO _____

IF (YES) LIST _____

DO YOU HAVE ANY REACTIONS TO ANY MEDICATIONS? YES _____ NO _____

IF (YES) LIST _____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:

ARTIFICIAL JOINT(S)	YES	NO	ARTIFICIAL HEART VALVE	YES	NO	KIDNEY PROBLEMS	YES	NO
DIABETIC	YES	NO	HIGH BLOOD PRESSURE	YES	NO	HEPATITIS	YES	NO
CANCER	YES	NO	HEART PROBLEMS	YES	NO	LIVER PROBLEMS	YES	NO
DO YOU USE TOBACCO	YES	NO	STOMACH PROBLEMS	YES	NO	TUBERCULOSIS	YES	NO
ANEMIA OR LEUKEMIA	YES	NO	BLEEDING PROBLEMS	YES	NO	HIV POSITIVE	YES	NO
VENEREAL DISEASE	YES	NO	TAKING CONTRACEPTIVES	YES	NO	SINUS OR ASTHMA	YES	NO
ARE YOU PREGNANT	YES	NO	LATEX ALLERGY	YES	NO	IMMUNE PROBLEMS	YES	NO

DO YOU HAVE ANY OTHER DISEASE OR CONDITION NOT LISTED? YES _____ NO _____

IF (YES) EXPLAIN _____

I CERTIFY THAT ALL OF THE ABOVE IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ DATE _____