

HEALTH HISTORY UPDATE

PATIENT'S NAME _____ BIRTHDAY ____/____/____

WINTER ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

SUMMER ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

CELLPHONE _____

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

IF (YES) REASON _____

PHYSICIANS' NAME _____ PHONE _____

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 MEDICATION? YES _____ NO _____

IF (YES) LIST _____

DO YOU HAVE 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) LIST _____

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

PATIENT SIGNATURE _____ DATE _____

(parent of minor)