

# HEALTH HISTORY

Patient Name \_\_\_\_\_  
First Name MI Last Name

Physician's Name \_\_\_\_\_ City \_\_\_\_\_ Date of last Visit \_\_\_\_\_  
First Name Last Name

Have you ever taken any of the group of drugs referred to as "Phen-Fen"  Yes  No  
Have you ever taken any of the group of drugs referred to as "bisphosphonates"?  Yes  No  
(fosamax, actonel, aredia, zometa)  
Have you been hospitalized or had a serious illness within the past 5 years?  Yes  No  
Do you require premedication with antibiotics for any of the following reasons?  
 Artificial Joints  Heart  Rheumatic Fever  Phen/Fen

## DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? CHECK (YES) OR (NO)

Y/N	Y/N	Y/N
<input type="checkbox"/> <input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Condition	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> <input type="checkbox"/> Diabetes (type _____)	<input type="checkbox"/> <input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> <input type="checkbox"/> Anemia (type _____)	<input type="checkbox"/> <input type="checkbox"/> Ear (Cochlear) Implant	<input type="checkbox"/> <input type="checkbox"/> Respiratory/Breathing
<input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> <input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> <input type="checkbox"/> Artificial Joints	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Steroid Treatment
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Back / Neck Problems	<input type="checkbox"/> <input type="checkbox"/> Heart Disease / Heart Surgery	<input type="checkbox"/> <input type="checkbox"/> TMJ Disorder
<input type="checkbox"/> <input type="checkbox"/> Bleeding Abnormality	<input type="checkbox"/> <input type="checkbox"/> Hepatitis (type _____)	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Blood Thinners	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Tumor or Growth
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Ulcer
<input type="checkbox"/> <input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Other _____

**FEMALES ONLY:** Are you Pregnant?  Yes  No Due Date \_\_\_\_\_  
Are you Nursing?  Yes  No  
Are you taking Birth Control Pills?  Yes  No

List any **MEDICATIONS** you are currently taking and correlating diagnosis:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:**  Aspirin or NSAIDs  Local Anesthetic  Latex  
 Penicillin (or other antibiotics)  Codeine  Sulfa Drugs  
 Iodine  Other \_\_\_\_\_

I have answered above completely and accurately.  
**Signature** (patient or parent/guardian) \_\_\_\_\_ **Date** \_\_\_\_\_