Patient Health & History Information

Patient's Name:_________________________________ DOB:________________

1. **Medical Doctor's Name**__________________________________
   Address____
   Phone____ **Pharmacy Phone**___________________________
2. Are you currently under medical care?________________________
   Since:__________ Condition:________________________
3. When was your last physical?____________________________ **Can you take RX in tablet form? Yes No**
4. **Please list prescribed medications:**____
   Please list any over the counter medications:____

4a. **Are you taking: Pamidronate (Aridia) Yes No / Zometa Yes No / Actonel Yes No / Fosamax Yes No**
Boniva Yes No / Reclast Yes No / Prolia Yes No / Denosumab Yes No

4b **Do you have - Osteoporosis Yes No / Osteopenia Yes No**

PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS

5. **Are you allergic to any medications/substances?** ____________________ **Yes No**
6. Are you allergic to penicillin or other antibiotics? ____________________ Yes No
7. Do you have any problems with local anesthetic? (Novacaine) __________ Yes No
8. Are you sensitive to any metals or latex? ____________________________ Yes No
9. **Are you pregnant or suspect you may be?**________**Due Date**__________ **Yes No**
10. **Do you take any birth control medications?**________________________ **Yes No**
11. **Have you ever been treated for heart murmur or heart disease?** ________ **Yes No**
12. **Do you have a pacemaker or an artificial heart valve implan**t?__________ **Yes No**
13. **Have you ever had rheumatic fever?**_______________________________ **Yes No**
14. Please check if you have high or low blood pressure____High______Low Yes No
15. Have you ever had a serious illness or major surgery?___________________ Yes No
    If so, explain ____
16. **Have you ever had radiation treatment, chemotherapy or cancer?**______ **Yes No**
17. Do you have soreness, clicking or popping in your jaw joint? ___________ Yes No
18. Do you have inflammatory diseases, such as arthritis or rheumatism?_______ Yes No
19. **Do you have any artificial joints/prosthesis/metal implants?**___________ **Yes No**
20. **Do you have any blood disorders, such as anemia, leukemia, hemophilia? Yes No**
21. **Have you ever had a heart attack or stroke?**_______________________ **Yes No**
22. Have you ever received a blood transfusion? Year_____________________ Yes No
23. Do you have stomach/kidney or liver problems? ______________________ Yes No
24. Are you diabetic?____ Yes No
25. Do you have asthma?____________Medications____________________ Yes No
26. Do you or have you had any sexually transmitted diseases?_____________ Yes No
27. **Have you tested HIV positive?**________________________________ **Yes No**
28. **Have you been diagnosed with having AIDS?** _____________________ **Yes No**
29. **Have you had or do you test positive for hepatitis?**__________________ **Yes No**
30. **Do you have or have you tested positive for tuberculosis?**____________ **Yes No**
31. Do you smoke, chew, use snuff or any other forms of tobacco? __________ Yes No
32. Do you consume alcoholic beverages? ____________________________ Yes No
33. Do you habitually use controlled substances? ______________________ Yes No
34. Have you ever bled uncontrollably from a cut? ______________________ Yes No
35. Have you ever had lung or breathing problems? ______________________ Yes No
36. Have you ever had fainting spells or seizures? ______________________ Yes No
37. Have you ever had hives or a skin rash? ___________________________ Yes No
38. Do you have thyroid problems? ________________________________ Yes No
39. Have you ever had persistent cough? _____________________________ Yes No
40. Have you ever had cough that produces blood? _____________________ Yes No
41. Do you have glaucoma? _______________________________________ Yes No
42. Is there anything else we should know that is not mentioned in this form? Yes No
    If yes please explain to the doctor ?_______________________________________

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Patient's /Guardian's Signature:______________________________ Date_____________

Reviewed By:____