

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Are you currently under the care of a physician? If YES, Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_

Describe your current physical health:  Excellent  Fair  Poor

Do you Smoke or use Smokeless Tobacco?  Yes  No Specify: \_\_\_\_\_

FOR WOMEN: Are you taking birth control pills?  Yes  No  
 Are you pregnant?  Yes  No If yes, # of weeks \_\_\_\_\_ Are you nursing?  Yes  No  
 Y  N Have you ever taken Boniva or Alendronate (Fosamax)? \_\_\_\_\_

Are you currently taking any  prescriptions  over the counter drugs  herbal supplements  appetite suppressants?

Do you now or have you ever had any of the following medical conditions?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease / Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia                | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis / Osteopenia    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur           | <input type="checkbox"/> Y <input type="checkbox"/> N Leukemia                  | <input type="checkbox"/> Y <input type="checkbox"/> N Stomach / Intestinal Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Irregular Heart Beat   | <input type="checkbox"/> Y <input type="checkbox"/> N Allergies (Seasonal)      | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Angina / Chest Pain    | <input type="checkbox"/> Y <input type="checkbox"/> N Pain in the Jaw           | <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions / Seizures       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack           | <input type="checkbox"/> Y <input type="checkbox"/> N Lung Disease              | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Failure          | <input type="checkbox"/> Y <input type="checkbox"/> N Breathing Problems        | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes - type: _____       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever        | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)         | <input type="checkbox"/> Y <input type="checkbox"/> N Hypoglycemia                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse  | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems            | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valve | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma - type: _____      | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis - type: _____      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Pacemaker        | <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema                 | <input type="checkbox"/> Y <input type="checkbox"/> N Jaundice                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery          | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease           | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems              |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure    | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting / Dizziness      | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis - type: _____      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure     | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                    | <input type="checkbox"/> Y <input type="checkbox"/> N Drug Use / Addiction         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Disease          | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment       | <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol Addiction            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                 | <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy              | <input type="checkbox"/> Y <input type="checkbox"/> N Cold Sores / Fever Blisters  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bruise Easily          | <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Joint: _____   | <input type="checkbox"/> Y <input type="checkbox"/> N Nervousness                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                 | <input type="checkbox"/> Y <input type="checkbox"/> N AIDS / HIV Positive       | <input type="checkbox"/> Y <input type="checkbox"/> N Depression                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Excessive Bleeding     | <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease: _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Other: _____                 |

Are you allergic to any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin            | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin     | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine            | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry / Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex            | <input type="checkbox"/> Y <input type="checkbox"/> N Other: _____ |

Y  N Have you ever been hospitalized or had any major operations? \_\_\_\_\_

Please list any over-the-counter or prescription drugs that you are currently taking.

Medication	Dosage	Reason for Taking Medication

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_