Health History

Patient name:_____ Age:____ Ht:____ Wt:____ Gender:_____

1. Are you in good health?..... Y N

2. Are you presently under the care of a physician for a chronic medical condition?..... Y N
   If so for what reason?_____
   _____

3. Have you had any serious illnesses, operations or hospitalizations?..... Y N
   If so, please describe_____
   _____

4. Do you have any of the following?

   Cardiovascular- *please circle those that apply*

   heart attack heart murmur/mitral valve prolapse high blood pressure stroke
   palpitations coronary artery disease heart surgery chest pain
   pacemaker congenital heart disease high cholesterol ..... Y N

   Respiratory- *please circle those that apply*

   asthma emphysema chronic cough bronchitis pneumonia
   lung surgery tuberculosis..... Y N

   Bleeding disorder- *please circle those that apply*

   anemia bleeding tendency need for transfusions bruise easily
   hereditary bleeding disorder..... Y N

   Liver disease..... Y N
   Kidney disease..... Y N
   Stomach ulcers, colitis..... Y N
   Arthritis..... Y N
   Artificial joint replacement..... Y N
   Seizures, convulsions, epilepsy..... Y N
   Thyroid disease..... Y N
   Cancer..... Y N
   Radiation Y N Chemotherapy Y N
   Diabetes..... Y N
   Glaucoma..... Y N
   Sinus/nasal problems..... Y N
   Psychiatric treatment..... Y N
   Any disease, drugs or transplant operation that would depress your immune system..... Y N

5. Please list all **medications** you are currently taking including prescription, non-prescription and herbal/natural supplements_____
   _____
   _____
   _____

6. Have you ever taken bisphosphonate or RANKL inhibitor medications (For example: Fosamax,
7. Zometa, Actonel, Boniva, Aredia, Prolia) for osteoporosis, multiple myeloma or other cancers? Y N

7. Please list all **allergies** including drugs, latex, food etc._____
   _____

8. Do you use alcohol? How much?..... Y N
9. Do you use tobacco? How much per day?_____For how long?_____..... Y N
10. Have you recently used any illegal drugs?..... Y N
11. **Women:** Are you pregnant, trying to become pregnant or any chance you might be pregnant? Y N
    Are you taking birth control pills? Y N Are you breastfeeding? Y N
12. Do you have a history of temporomandibular joint disorder/facial pain? Y N
13. Do you have any other diseases/conditions the doctor should know about..... Y N

I understand the importance of an accurate health history. The above questions have been answered to the best of my knowledge. Signed:_____ Date:_____