

## HEALTH HISTORY

Physician's name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. YES NO

Have you ever taken any of the group of the drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). YES NO

**Highlight** or circle "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	YES	NO	Epilepsy	YES	NO	Respiratory Disease	YES	NO
Anemia	YES	NO	Fainting or dizziness	YES	NO	Rheumatic Fever	YES	NO
Arthritis, Rheumatism	YES	NO	Glaucoma	YES	NO	Scarlet Fever	YES	NO
Artificial Heart Valves	YES	NO	Headaches	YES	NO	Shortness of Breath	YES	NO
Artificial Joints	YES	NO	Heart Murmur	YES	NO	Sinus Trouble	YES	NO
Asthma	YES	NO	Heart problems	YES	NO	Skin Rash	YES	NO
Back Problems	YES	NO	Hepatitis Type _____	YES	NO	Special Diet	YES	NO
Bleeding abnormally, with extractions or surgery	YES	NO	Herpes	YES	NO	Stroke	YES	NO
Blood Disease	YES	NO	High Blood Pressure	YES	NO	Swollen Feet or Ankles	YES	NO
Cancer	YES	NO	Jaundice	YES	NO	Thyroid Problems	YES	NO
Chemical Dependency	YES	NO	Jaw Pain	YES	NO	Tonsillitis	YES	NO
Chemotherapy	YES	NO	Kidney Disease	YES	NO	Tuberculosis	YES	NO
Circulatory Problems	YES	NO	Liver Disease	YES	NO	Tumor of growth on head or neck	YES	NO
Congenital Heart Lesions	YES	NO	Low Blood Pressure	YES	NO	Ulcer	YES	NO
Cortisone Treatments	YES	NO	Mitral Valve Prolapse	YES	NO	Venereal Disease	YES	NO
Cough, persistent or bloody	YES	NO	Nervous Problems	YES	NO	Weight Loss, unexplained	YES	NO
Diabetes	YES	NO	Pacemaker	YES	NO			
Emphysema	YES	NO	Psychiatric Care	YES	NO			
			Radiation Treatment	YES	NO	Do you wear contact lenses?	YES	NO

### Women:

Are you pregnant? \_\_\_\_\_ Due date \_\_\_\_\_ Are you nursing? YES NO Taking birth control pills? YES NO

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy's name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

## ALLERGIES

Please **highlight** any allergies

Aspirin	Latex
Barbiturates (Sleeping pills)	Local Anesthetic
Codeine	Penicillin
Iodine	Sulfa

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_