
# Medical History

**Full Name** **Date**

First Name Last Name Month Day Year

**GENDER** ❍ MALE ❍ FEMALE

**ARE YOU UNDER A PHYSICIAN CARE?** ❍ Yes ❍ No

**HAVE YOU EVER BEEN HOSPITALIZED?** ❍ Yes ❍ No

**MEDICAL CONDITIONS:**

| | | |
|---|---|---|
| ❑ DIABETES | ❑ HIGH BLOOD PRESSURE | ❑ HIGH CHOLESTEROL |
| ❑ HISTORY OF HEART ATTACK | ❑ HEART DISEASE | ❑ HISTORY OF JOINT REPLACEMENT |
| ❑ ARTIFICIAL HEART VALVE | ❑ HEART PACEMAKER | ❑ TAKING BLOOD THINNERS |
| ❑ STROKE | ❑ KIDNEY DISEASE/ DIALYSIS | ❑ LIVER DISEASE OR HEPATITS A |
| ❑ CANCER / LEUKEMIA | ❑ CHEMOTHERAPY/ RADIOTHERAPY | ❑ EPILEPSY/ SEIZURE DISORDERS |
| ❑ GLAUCOMA | ❑ ASTHMA | ❑ LUNG DISEASE / COPD |
| ❑ TUBERCULOSIS | ❑ HIV/ AIDS POSITIVE | ❑ HEPATITIS B OR C |
| ❑ VENEREAL DISEASE | ❑ ANEMIA/ SICKLE CELL DISEASE | ❑ BLEEDING OR BRUISING EASILY |
| ❑ GI PROBLEMS / ULCERS | ❑ CORTISONE/STEROID TREATMENTS | ❑ PENICILLIN ALLERGY |

**ARE YOU TAKING ANY MEDICATIONS?** ❍ Yes ❍ No

**DO YOU HAVE ANY ALLERGIES?** ❍ Yes ❍ No

**PLEASE LIST ALLERGIES, OTHER MEDICAL CONDITIONS AND CURRENT MEDICATIONS:**

**ARE YOU PREGNANT?** ❍ Yes ❍ No

**DO YOU SMOKE?** ❍ Yes ❍ No

**DO YOU USE CONTROLLED SUBSTANCES?** ❍ Yes ❍ No

**ALCOHOL CONSUMPTION?** ❍ Yes ❍ No

**HISTORY OF BISPHOSPHONATES Tx?** ❍ Yes ❍ No

**SIGNATURE AND DATE:**

**E-mail**