HEALTH HISTORY

Physician's name _____

Address _____ Phone _____ Date of last visit _____

Y N

☐ ☐ Do you need premedication? Why?_____ What medication? _____

Have you ever taken any of the following group of drugs?

☐ ☐ Fen-phen? These include combinations of Ionimin, Adipex, Fastin (phentermine), Prodimin (fenfluramine) and Redux (dexfenfluramine) and etc. When and how? _____

☐ ☐ Bisphosphonates? These include combinations of Actonel, Boniva, Didronel, Fosamax, Skelid, Aredia, Bonefos, Ostac, Zometa and etc. When and how? _____

☐ ☐ Steroids? These include hydrocortisone, prednisolone, betamethaasone, dexamethasoone, triamcinolone, and etc. When and how? _____

Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV	☐	☐	Epilepsy	☐	☐	Respiratory disease
☐	☐	Anemia	☐	☐	Fainting or dizziness	☐	☐	Rheumatic fever
☐	☐	Arthritis, rheumatic	☐	☐	Glaucoma	☐	☐	Scarlet fever
☐	☐	Artificial heart valves	☐	☐	Headaches	☐	☐	Shortness of breath
☐	☐	Artificial joints	☐	☐	Heart Murmur	☐	☐	Snius trouble
☐	☐	Asthma	☐	☐	Heart problems	☐	☐	Skin rash
☐	☐	Back problems	☐	☐	Hepatitis type _____	☐	☐	Special diet
☐	☐	Bleeding abnormally, with extractions or surgery	☐	☐	Herpes	☐	☐	Stroke
			☐	☐	High blood pressure	☐	☐	Swollen feet or ankles
☐	☐	Blood disease	☐	☐	Jaundice	☐	☐	Swollen neck glands
☐	☐	Cancer	☐	☐	Jaw pain	☐	☐	Thyroid problems
☐	☐	Chemical dependency	☐	☐	Kidney disease	☐	☐	Tonsilitis
☐	☐	Chemotherapy	☐	☐	Liver disesae	☐	☐	Tuberculosis
☐	☐	Circulatory problems	☐	☐	Low blood pressure	☐	☐	Tumor or growth
☐	☐	Congenital heart lesions	☐	☐	Mitral valve prolapse			_____
☐	☐	Cortisone treatment	☐	☐	Nervous problems	☐	☐	Ulcer
☐	☐	Cough, persistent or bloody	☐	☐	Pacemaker	☐	☐	Venereal disease
☐	☐	Diabetes	☐	☐	Psychiatric care	☐	☐	Weight loss, unexpected
☐	☐	Emphysema	☐	☐	Radiation treatment	☐	☐	Other _____

WOMEN

☐ ☐ Pregnant Due date _____ Conditoin _____

☐ ☐ Birth control pill ☐ ☐ Nursing

MEDICATIONS

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

_____

_____

_____

Pharmacy name _____ Phone _____

Address _____

ALLERGY & ADVERSE REACTION

List everything you are allergic to or have adverse reaction, including medication, food and environmental factors

_____

_____

_____

SIGNATURE

Patient's signature_____ Date _____

Staff's signature _____ Date _____

Doctor's signature _____ Date _____