PATIENT MEDICAL HISTORY

Patients Name: | Today's Date | Date of Last Visit:

Address:

City, State, Zip: | Email:

Home Phone: | Work Phone: | Cell Phone:

Birth Date: | Marital Status: | Social Security No:

Physician's Name: | Physician's Phone:

Pharmacy: | Pharmacy Phone:

Y N

☐ ☐ Any medical diagnoses, treatments or surgeries in the past 6 months: Please list changes in box below.

Sex:

If Female, please answer the following:

Y N

☐ ☐ Are you taking Birth Control Pills?

☐ ☐ Are you pregnant?

If Yes, # of weeks

☐ ☐ Are you nursing

Please answer the following:

Y N

☐ ☐ Do you smoke or use Tobacco?

How much? _____

Height: ☐

Weight: ☐

Please mark Yes or No to all of the following:

Y N	CONDITIONS
☐ ☐	Abnormal Bleeding
☐ ☐	Alcohol Abuse
☐ ☐	Allergic to Bleach
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Arthritis
☐ ☐	Artificial Bones or Joints-what?_____
☐ ☐	Artificial Heart Valve-when?_____
☐ ☐	Asthma
☐ ☐	Blood Transfusion-when?_____
☐ ☐	Bruise Easily
☐ ☐	Cancer – Chemotherapy-when?____
☐ ☐	Cancer – No Chemotherapy
☐ ☐	Congenital Heart Defect
☐ ☐	Cosmetic Surgery
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Drug Abuse
☐ ☐	Drug Abuse – History of
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Fever Blisters

Y N	CONDITIONS
☐ ☐	Frequent Headaches
☐ ☐	Glaucoma
☐ ☐	HIV + Aids
☐ ☐	Heart Attack-when?_____
☐ ☐	Heart Murmur
☐ ☐	Heart Problems-what?_____
☐ ☐	Hemophilia
☐ ☐	Hepatitis-which form?_____
☐ ☐	High Blood Pressure
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Pace Maker
☐ ☐	Pain in Jaw Joints
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy-when?_____
☐ ☐	Rheumatic Fever
☐ ☐	Seizures when was last? _____
☐ ☐	Shingles
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems
☐ ☐	Stroke-when?_____

Y N	CONDITIONS
☐ ☐	Thyroid Problems
☐ ☐	Venereal Disease
☐ ☐	Osteoporosis
☐ ☐	Osteopenia
☐ ☐	Taken Fen-Phen
☐ ☐	Endocarditis-when?_____

ALLERGIES

Y N	
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Amoxicillin
☐ ☐	Tetracycline

Other:

_____

_____

_____

Y N

☐ ☐ Prescription or Over the Counter Medications and/or supplements:

Y N

☐ ☐ Have you ever taken any of the following medications? They are commonly used for conditions such as cancer (chemotherapy), osteoporosis and/or arthritis. If yes, please mark below:

Orally administered	Bisphosphonates	Dates started	Dates stopped
Brand Name	Generic Name		
Actonel	risedronate		
Boniva	ibandronate		
Fosamax	alendronate		
Fosamax Plus D	alendronate		
Skelid	tiludronate		
Didronel	etidronate		
Intravenously administered	**Bisphosphonates**	**Dates started**	**Dates stopped**
Brand Name	Generic Name		
Aredia	pamidronate		
Zometa	zolendronic acid		
Bonefos	clodronate		
Didronel	etidronate		
Reclast	zoledronic acid		
Xgeva	denosumab		

Y N

☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below:

Signature:_____ Date:_____

(If under 18, Parent of Guardian Signature Required)