Health Information Form

Patient's Name: _____ Date of Birth: _____

Physician's Name: _____ Date of Last Visit: _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
3. If yes, please explain: _____		
4. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, please list: _____		
5. Are you currently taking or have you taken any bisphosphonate? (e.g. Boniva,Fosamax)	☐	☐
6. Have you ever undergone chemotherapy?	☐	☐
7. **Women Only:**		
Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

8. Are you allergic to or have you had any reactions to the following?	YES	NO
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐

Place a mark on "yes" or "no" to indicate if you have had any of the following:

YES	*NO*	
☐	☐	AIDS/HIV
☐	☐	Anemia
☐	☐	Arthritis, Rheumatism
☐	☐	Artificial Heart Valves
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Back Problems
☐	☐	Blood Disease
☐	☐	Cancer
☐	☐	Chemical Dependency
☐	☐	Chemotherapy
☐	☐	Circulatory Problems
☐	☐	Congenital Heart Lesions
☐	☐	Cortisone Treatments
☐	☐	Cough, persistent or bloody
☐	☐	Diabetes
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting or dizziness
☐	☐	Glaucoma
☐	☐	Headaches
☐	☐	Heart Murmur
☐	☐	Heart Problems
☐	☐	Hepatitis Type____

YES	*NO*	
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	Jaundice
☐	☐	Kidney Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Pro-lapse
☐	☐	Psychiatric Care
☐	☐	Radiation Treatment
☐	☐	Respiratory Disease
☐	☐	Rheumatic Fever
☐	☐	Scarlett Fever
☐	☐	Shortness of Breath
☐	☐	Sinus Trouble
☐	☐	Skin Rash
☐	☐	Special Diet
☐	☐	Stroke
☐	☐	Swollen Feet or Ankles
☐	☐	Swollen Neck Glands
☐	☐	Thyroid Problems
☐	☐	Tonsillitis
☐	☐	Tuberculosis
☐	☐	Tumor or growth
☐	☐	Ulcer
☐	☐	Venereal Disease