Patient Health History

Name: _____ Date: _____

Patient's Medical Doctor: _____ Medical Doctor's Phone Number: _____

Patient's Emergency Contact: _____ Emergency Phone Number: _____

Please circle YES or NO to indicate if you have or had any of the following:

Low Blood Pressure	Yes	No		Blood Disease	Yes	No	
High Blood Pressure	Yes	No		Migraines/Headaches	Yes	No	
Respiratory/Asthma	Yes	No		Epilepsy/Fainting	Yes	No	
Emphysema	Yes	No		MRSA	Yes	No	
Recent Surgery	Yes	No	Type: _____	Psychiatric Care	Yes	No	
Rheumatic Fever	Yes	No		Tumor/Neoplasms	Yes	No	
Anemia/Bleeding	Yes	No		Chemical Dependency	Yes	No	
Diabetes	Yes	No		Infectious Diseases	Yes	No	
High Cholesterol	Yes	No		Venereal Disease	Yes	No	
Thyroid/Hormonal	Yes	No		Tuberculosis	Yes	No	
Liver Disease	Yes	No		Cold Sores	Yes	No	
Kidney Disease	Yes	No		Hepatitis	Yes	No	Type: _____
Stroke	Yes	No		AIDS/HIV	Yes	No	
Arthritis	Yes	No		Immunocompromised	Yes	No	
Heart Disease	Yes	No		Cancer	Yes	No	
Mitral Valve Prolapse	Yes	No		Radiation Treatment	Yes	No	
Pacemaker	Yes	No		Chemotherapy	Yes	No	
Artificial Valve	Yes	No	Year: _____	Jaw Pain	Yes	No	
Heart Attack	Yes	No		Sinus Problems	Yes	No	
Heart Murmur	Yes	No		Currently Pregnant	Yes	No	
Artificial Joint	Yes	No	Year: _____				

Have you ever taken medication for your bone health? Yes No If so, what? _____

ALLERGIES:			**Medications: If Yes, please state what medication**	
Penicillin	Yes	No	No Medications:	Initial if taking no medications
Erythromycin	Yes	No	Antibiotic	
Clindamycin	Yes	No	Pain Medicine	
Tylenol	Yes	No	Heart Medicine	
Codeine	Yes	No	Aspirin	
Narcotics	Yes	No	Cortisone/Steroid	
Local Anesthetic	Yes	No	Blood Thinner	
Latex	Yes	No	Blood Pressure	
Ibuprofen/Advil/Motrin	Yes	No	Insulin	
Chlorine Bleach	Yes	No	Oral Diabetes Medication	
Iodine	Yes	No	Thyroid	
Aspirin	Yes	No	Antidepressant	
Epinephrine	Yes	No	Anti-anxiety	
Valium/Tranquilizers	Yes	No	Birth Control Pills	
Sulfa	Yes	No	Inhaler	
OTHER (List): _____			Hormones	
_____			Anti-inflammatory	
_____			Cancer Medications	
			Cholesterol	
			Other Medications	

I acknowledge that I have reviewed ALL questions. There are no other medical conditions or allergies that have not been listed.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

OCSE: _____ B/P: _____ Pulse: _____