

HEALTH HISTORY

NAME _____ DATE _____

- 1) How much do you weigh? _____ How tall are you? _____
- 2) Are you allergic to Latex or any medications? Y N If yes, please list
- 3) Are you taking Coumadin, Plavix or any other blood thinner? Y N
- 4) Are you taking any medications or herbal supplements? Y N If yes, please list
- 5) Have you ever had any of the following? Y N If yes, please check those that apply

Irregular heart rate	Joint replacement (When ? _____ by Dr. ? _____)	
Heart disease	Asthma or breathing difficulty	Bleeding problems
Pacemaker	Heart attack or stroke	Cancer
High blood pressure	Hepatitis or HIV/Aids	Kidney disease
Heart valve replacement (by Dr ? _____)	Diabetes: diet controlled ?	
Other conditions:	oral medication ?	
	insulin controlled ?	
	usual serum glucose level ? _____	

- 6) Have you ever taken: Aredia, Zometa, Fosamax, Boniva, Actonel, Didronel, Skelid, Reclast or other drugs to treat bone cancer or osteoporosis (excluding calcium)? Y N If yes, please circle
- 7) Have you had eye surgery within the past 8 weeks? Y N
- 8) Have you taken Prednisone or steroids in the past 3 months? Y N
- 9) Do you use tobacco? Y N Smoke Chew How much?
- 10) Have you ever been admitted to a hospital? Y N If yes, please explain
- 11) Have you ever had problems with general anesthesia? Y N
- 12) **Women:** Are you pregnant? Y N Are you currently breast-feeding? Y N
- 13) Do you have other health problems? Y N If yes, please explain

Date

Signature

Completed by: Patient Parent Spouse Guardian Other
(please circle)