Health History

Medical History

1) Do you have or ever had any of the following?

AIDS/HIV Infection -	Alcohol Dependency -	Anemia -
Angina/Chest Pain -	Arthritis/ Rheumatism -	Asthma -
Blood Disease -	Blood Transfusion -	Cancer -
Chemical Dependency -	Chemotherapy -	Cortisone Treatment -
Diabetes -	Epilepsy -	Glaucoma -
Hay Fever/Allergies -	Headaches (frequently) -	Date -
Heart Attack -	Heart Disease -	Heart Murmur -
Hemophilia -	Hepatitis -	Type: -
High Blood Pressure -	Joint/hip Replacement -	Date -
Kidney Disease -	Liver Disease -	Mental Disorders -
Mitral Valve Prolapse -	Pacemaker -	Prosthetic Heart Valve -
Radiation Treatment -	Respiratory Disease -	Rheumatic Fever -
Sexually Transmitted Disease -	Shortness of Breath -	Sinus Problems -
Stomach Problems/ Ulcers -	Stroke -	Date -
Thyroid Disease -	Tuberculosis -	Tumors -
Have you taken, plan to take or currently on Prolia (Denosumab)? -	If yes, Please specify timeline: -	Other: -

2) Are you allergic to or have you had any reactions to the following?

☐ Aspirin	☐ Codeine	☐ Iodine	☐ Latex
☐ Local Anesthetic (e.g. Novocain)	☐ Metals (e.g. nickel, mercury,etc.)	☐ Nitrous	☐ Penicillin
☐ sulfa Drugs	☐ Tetracycline	☐ I Do Not Have Any Known Allergies "	☐ other

(please list):. -	3) Are you taking any medication(s) including non-prescription drugs? -	If yes, please list medications /supplements: -

4) Date of last physical exam:
-

Physician's Name:
-

Office Phone#:
-

5) Are you under medical treatment now?
-

If yes, please explain:
-

6) Have you been hospitalized for any surgical operation or serious illness during the past five years?
-

If yes, please explain:
-

7) Do you use tobacco?
-

9) Do you or have you taken Bisphosphonates (e g. Fosamax, Actonel, etc.)?
-

10) Women Only:

Are you pregnant or think you may be pregnant?
-

Due Date:
-

Are you nursing?
-

Are you taking oral contraceptives?
-

Date
-

E-Signature (draw, upload or type) (ESign)

Date :