PATIENT HEALTH HISTORY

NAME_____DATE_____
PATIENT'S PHYSICIAN_____ PHYSICIAN'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	Y	N	Blood Disease	Y	N
High Blood Pressure	Y	N	Migraines/Headaches	Y	N
Respiratory/Asthma	Y	N	Epilepsy/Fainting	Y	N
Emphysema	Y	N	Glaucoma/Visual	Y	N
Scarlet Fever	Y	N	Psychiatric Care	Y	N
Rheumatic Fever	Y	N	Tumor/Neoplasm's	Y	N
Anemia/Bleeding	Y	N	Chemical Dependency	Y	N
Diabetes	Y	N	Infectious Diseases	Y	N
High Cholesterol	Y	N	Venereal Disease	Y	N
Thyroid/Hormonal	Y	N	Tuberculosis	Y	N
Liver Disease	Y	N	Cold Sores	Y	N
Kidney Disease	Y	N	Hepatitis	Y	N
Back Problems	Y	N	Aids/HIV	Y	N
Arthritis	Y	N	Imunocompromised	Y	N
Heart Disease	Y	N	Cancer	Y	N
Mitral Valve Prolapse	Y	N	Radiation Treatment	Y	N
Pacemaker	Y	N	Chemotherapy	Y	N
Artificial Valve	Y	N	Jaw Pain	Y	N
Heart Attack/Stroke	Y	N	Sinus Problems	Y	N
Heart Murmur	Y	N	Artificial Joint	Y	N
			Currently Pregnant	Y	N

Have you ever taken medication for your bone health? Y N

ALLERGIES:

Penicillin	Y	N
Erythromycin	Y	N
Clindamycin	Y	N
Tylenol	Y	N
Codeine	Y	N
Narcotics	Y	N
Local Anthesthetic	Y	N
Latex	Y	N
Ibuprofen/Advil/Motrin	Y	N
Chlorine Bleach	Y	N
Iodine	Y	N
Aspirin	Y	N
Epinephrine	Y	N
Valium/Tranquilizers	Y	N
Sulfa	Y	N

OTHER (List) _____
_____

MEDICATIONS: If yes please state what medication.

No Medications_____ initial if taking no medications
Antibiotic_____
Pain Medicine_____
Heart Medicine_____
Aspirin_____
Cortisone/Steroid_____
Blood Thinner_____
Blood Pressure_____
Insulin_____
Oral Diabetes Medication_____
Thyroid_____
Anti-Depressant_____
Anti-Anxiety_____
Birth Control Pills_____
Inhaler_____
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_____