Health History

Name

Last____________________________________ First__________________Middle__________

Address_________________________________ City__________________ State_____ Zip_______

Date of Birth _____/_____/______ Home Phone (_____)_____________________

Cell Phone (_____)_____________________

Medical History

Primary Physician _______________________

Address/City/State_______________________

Phone Number (____)__________________

Are you now under the care of a physician? Yes No

Have you had any serious illness, operation or been hospitalized in the last 5 years? Yes No

If yes, what was the illness or problem?

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Medications: Are you taking currently or have you recently taken any prescription or over the counter medications? Yes No

If so, please list all, including vitamins and supplements:

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Allergies: Are you allergic to, or had an adverse reaction to any of the following:

Local Anesthetic	Yes	No
Penicillin	Yes	No
Sulfa drugs	Yes	No
Latex (Rubber)	Yes	No
Codeine or other narcotics	Yes	No

Joint Replacement: Have you had any total joint (hip, knee, elbow) replacement? Yes No

Date Placed ________________

If yes, have you had any complications? Yes No
Please explain:

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Are you currently taking or scheduled to begin taking IV bisphosphonates? Yes No

Do you have a history of:

Congenital Heart Disease	Yes	No
Artificial Heart Valve	Yes	No
Infective Endocarditis	Yes	No
Damaged valves in a transplanted heart	Yes	No

Do you have any existing disease, condition or problem not listed above? Yes No
If yes, please explain:

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Signature of Patient/Legal Guardian:

___________________________ Date: ___________