Patient Name and Date of Birth: *

Health Information

Have you ever had any of the following conditions? Please check all that apply. Please list any others not included.

- ☐ AIDS
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BLOOD DISEASE
- ☐ CANCER
- ☐ DIABETES
- ☐ DIZZINESS
- ☐ DRUG ADDICTION
- ☐ EPILEPSY
- ☐ EXCESSIVE BLEEDING
- ☐ FAINTING
- ☐ GLAUCOMA
- ☐ BENIGN GROWTHS
- ☐ HAY FEVER
- ☐ HEAD INJURIES
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MENTAL DISORDERS
- ☐ NERVOUS DISORDERS
- ☐ PACEMAKER/DEFIBRILLATOR
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATISM
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ TUMORS
- ☐ THYROID
- ☐ VENERAL DISEASE

Conditions not listed:

ALLERGIES

- ☐ ASPIRIN
- ☐ CODEINE
- ☐ DENTAL ANESTHETICS
- ☐ ERYTHROMYCIN
- ☐ METALS
- ☐ LATEX
- ☐ PENICILLIN
- ☐ CLINDAMYCIN
- ☐ TETRACYCLINE
- ☐ ZITHROMAZ (Z-PACK)

Other Allergies not listed above:

Are you currently PREGNANT or NURSING? If so which trimester are you in?

◯ Yes ◯ No ◯ First trimester ◯ Second trimester ◯ Third trimester

Name of your PRIMARY CARE PHYSICIAN? * _____

PHARMACY of choice and LOCATION: _____

Do you SMOKE, VAPE or CHEW TOBACCO? * ◯ Yes ◯ No

Have you ever taken FOSOMAX, BONIVA, ACTONOL or any medications containing BIPHOSPHONATES? ◯ Yes ◯ No

Do you take any BLOOD THINNERS? ◯ Yes ◯ No

Please list all medications: *

Response Date: _____