ALLERGIES

*Please highlight any allergies*

|  |  |
| --- | --- |
| AspirinBarbiturates (Sleeping pills)CodeineIodine | LatexLocal AnestheticPenicillinSulfa |

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH HISTORY

Physician’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. YES NO
Have you ever taken any of the group of the drugs collectively referred to as “fen-phen?” These include combinations of Ionimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). YES NO

*Highlight or circle “yes” or “no” to indicate if you have had any of the following:*

|  |  |  |
| --- | --- | --- |
| AIDS/HIV YES NOAnemia YES NOArthritis, Rheumatism YES NOArtificial Heart Valves YES NOArtificial Joints YES NOAsthma YES NOBack Problems YES NOBleeding abnormally, with YES NO extractions or surgeryBlood Disease YES NOCancer YES NOChemical Dependency YES NOChemotherapy YES NOCirculatory Problems YES NOCongenital Heart Lesions YES NOCortisone Treatments YES NOCough, persistent or bloody YES NODiabetes YES NOEmphysema YES NO | Epilepsy YES NOFainting or dizziness YES NOGlaucoma YES NOHeadaches YES NOHeart Murmur YES NOHeart problems YES NOHepatitis Type \_\_\_\_\_ YES NOHerpes YES NOHigh Blood Pressure YES NOJaundice YES NOJaw Pain YES NOKidney Disease YES NOLiver Disease YES NOLow Blood Pressure YES NOMitral Valve Prolapse YES NONervous Problems YES NOPacemaker YES NOPsychiatric Care YES NORadiation Treatment YES NO | Respiratory Disease YES NORheumatic Fever YES NOScarlet Fever YES NOShortness of Breath YES NOSinus Trouble YES NOSkin Rash YES NOSpecial Diet YES NOStroke YES NOSwollen Feet or Ankles YES NOThyroid Problems YES NOTonsillitis YES NOTuberculosis YES NOTumor of growth on head or YES NO neckUlcer YES NOVenereal Disease YES NOWeight Loss, unexplained YES NODo you wear contact lenses? YES NO |

**Women:**Are you pregnant? \_\_\_\_\_ Due date \_\_\_\_\_\_\_\_\_\_ Are you nursing? YES NO Taking birth control pills? YES NO