ALLERGIES

*Please highlight any allergies*

|  |  |
| --- | --- |
| Aspirin  Barbiturates (Sleeping pills)  Codeine  Iodine | Latex  Local Anesthetic  Penicillin  Sulfa |

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 NO Anemia YES NO Arthritis, Rheumatism YES NO Artificial Heart Valves YES NO Artificial Joints YES NO Asthma YES NO Back Problems YES NO Bleeding abnormally, with YES NO  extractions or surgery Blood Disease YES NO Cancer YES NO Chemical Dependency YES NO Chemotherapy YES NO Circulatory Problems YES NO Congenital Heart Lesions YES NO Cortisone Treatments YES NO  Cough, persistent or bloody YES NO Diabetes YES NO Emphysema YES NO | Epilepsy YES NO Fainting or dizziness YES NO Glaucoma YES NO  Headaches YES NO  Heart Murmur YES NO  Heart problems YES NO  Hepatitis Type \_\_\_\_\_ YES NO  Herpes YES NO  High Blood Pressure YES NO  Jaundice YES NO  Jaw Pain YES NO  Kidney Disease YES NO Liver Disease YES NO  Low Blood Pressure YES NO Mitral Valve Prolapse YES NO  Nervous Problems YES NO  Pacemaker YES NO Psychiatric Care YES NO  Radiation Treatment YES NO | Respiratory Disease YES NO  Rheumatic Fever YES NO Scarlet Fever YES NO Shortness of Breath YES NO  Sinus Trouble YES NO  Skin Rash YES NO  Special Diet YES NO  Stroke YES NO  Swollen Feet or Ankles YES NO  Thyroid Problems YES NO  Tonsillitis YES NO  Tuberculosis YES NO  Tumor of growth on head or YES NO  neck  Ulcer YES NO  Venereal Disease YES NO  Weight Loss, unexplained YES NO  Do you wear contact lenses? YES NO |

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