Medical History

___Yes	___No	1. Do you have (or have you ever had) any of the following?
___Yes	___No	a. allergic reaction to drugs or latex (Circle all that apply)
		Latex PCN Aspirin Codeine Local Anesthetics Other_____
___Yes	___No	b. heart attack or heart disease
___Yes	___No	c. Stroke
___Yes	___No	d. High blood pressure
___Yes	___No	e. Congestive heart failure
___Yes	___No	f. Angina (chest pains)
___Yes	___No	g. Irregular heart beat
___Yes	___No	h. Artificial heart valve
___Yes	___No	i. Rheumatic fever, rheumatic heart disease, bacterial endocarditis
___Yes	___No	j. Congenital heart disease
___Yes	___No	k. Heart murmer or mitral valve prolapse
___Yes	___No	l. Immunosuppressive condition (circle all that apply)
		Steriod Therapy (e.g. prednisone) Radiation or Cancer Therapy SLE (Lupus) Rheumatoid Arthritis HIV Organ Transplant Spleen Removed Other_____
___Yes	___No	m. Artificial joints(s) (circle all that apply)
		Hip Knee Ankle Shoulder Other_____ Date(s) placed
___Yes	___No	n. Bleeding problem, anemia, or other liver disease
___Yes	___No	o. Diabetes
___Yes	___No	p. Thyroid disease
___Yes	___No	q. Long term antibiotic use (greater than one month continuously)
___Yes	___No	r. Nervous system disease or seizures
___Yes	___No	s. Kidney disease
___Yes	___No	t. Hepatitis (A, B, C, or D) or other liver disease
___Yes	___No	u. Muscle or joint disease or arthritis (osteo or rheumatoid)
___Yes	___No	v. Asthma, tuberculosis, or other lung disease
___Yes	___No	w. Stomach or intestinal disease
___Yes	___No	x. Mental health condition - specify:
___Yes	___No	y. Physical or mental disabilities that may require special care?
___Yes	___No	z. Do you have or have you ever been treated for cancer?
___Yes	___No	2. Are you or could you be pregnant? Are you nursing?
___Yes	___No	3. Do you have any disease, condition, or problem?
___Yes	___No	Describe:
___Yes	___No	4. Have you ever been hospitalized or had surgery?
		Describe:
___Yes	___No	5. Do you have any symptoms that have not been diagnosed by a doctor?
		Describe:
___Yes	___No	6. Are you or have you ever been addicted to a chemical substance?
___Yes	___No	7. Do you currently drink alcohol?
___Yes	___No	8. Do you use recreational drugs?
___Yes	___No	9. Do you use tobacco products? Type:
___Yes	___No	10. Do you regularly take herbal medicines or dietary supplements? Specifically:
		Echinacea Garlic Ginger Kava Valerlan Feverfew Ginko Ginseng St. Johns Wort Vitamin E
___Yes	___No	11. Have you undergone current or past osteoporsis therapy? (i.e. Fosamax, Actonel, Boniva)
___Yes	___No	12. Have you undergone current or past therapy to reduce high blood calcium
		(biophosphate therapy)? (i.e. intravenous Aredia, Zometa)
List Medications:		