Patient Name: _____ _____ ___ _____
Last First M Preferred Name

Birth Date _____

Physician's name and phone number:

List any medications or herbal supplements you are presently taking:

Have you ever been treated for osteoporosis or taken any medication to treat this condition? ◯ Yes ◯ No

Have you been treated in the hospital in the last 2 years and for what condition or problem?

Have you ever had any major surgery?

Have you become sick from or have an allergy to any of the following:

☐ Penicillin ☐ Amoxicillin ☐ Clindamycin ☐ Sulfa Drugs ☐ Codeine ☐ Aspirin

☐ Latex ☐ Metals ☐ Local Anesthetics

Are you allergic to anything else?

Do you smoke or chew tobacco? ◯ Yes ◯ No

If female, are you pregnant or nursing?

Have you ever had or do you now have any of the following:

☐ AIDS or HIV	☐ Acid reflux (GERD)	☐ Alcohol dependency	☐ Allergies (environmental)
☐ Anemia	☐ Angina	☐ Artificial heart valve	☐ Artificial joints
☐ Arthritis/ rheumatism	☐ Asthma	☐ Bleeding disorder	☐ Blood thinner medication
☐ Canker sores/apthous ulcers	☐ Cancer	☐ Cardiac pacemaker	☐ Chemotherapy/ radiation
☐ Congenital heart lesions	☐ Diabetes	☐ Drug dependency	☐ Emphysema or COPD
☐ Epilepsy/seizures	☐ Eye disease	☐ Fainting	☐ Glaucoma
☐ Headaches	☐ Heart attack	☐ Heart disease	☐ Heart murmur
☐ Heart surgery	☐ Hemophilia	☐ Hepatitis	☐ Herpes labialis/cold sores
☐ High blood pressure	☐ Illegal drug use	☐ Irregular heartbeat	☐ Kidney disease
☐ Leukemia	☐ Liver Disease	☐ Low blood pressure	☐ Mitral valve prolapse
☐ Organ transplant	☐ Osteoporosis	☐ Prolonged cough	☐ Psychiatric treatment
☐ Respiratory problems	☐ Sickle cell anemia	☐ Sinus trouble	☐ Stroke
☐ Thyroid disease	☐ Tuberculosis	☐ Ulcers	

Dates or notes about any conditions:

_____

_____

Do you have any other disease, condition or problem not listed?

_____

_____

_____

Response Date: ____/____/_____