HEALTH HISTORY

PATIENT NAME:	DATE OF BIRTH:

Have you had any of the following?

□Allergies
□Anemia
□Anorexia
□Anxiety
□Arthritis
□Artificial Heart Valve
□Artificial Joint
□Asthma
□Back pain
□Blood Disease
□Blood Transfusion
□Bulimia
□Cancer
□Coronary Bypass
□Diabetes
□Dizziness
□Epilepsy
□Excessive Bleeding
□Fainting
□Fibromyalgia
□Food Allergies
□Gastric Reflux
□Glaucoma
□Growths
□Headaches
□Head Injuries
□Hearing Loss
□Heart Attack
□Heart Disease
□Heart Murmur
□Heartburn
□Hepatitis
□High Blood pressure
□High Cholesterol
□HIV/AIDS
□Jaundice
□Kidney Disease
□Liver Disease
□Low Blood pressure
□Lupus Erythematosus
□Medication Allergies
□Mitral Valve Prolapse
□Neck Pain
□Pacemaker
□Panic Attacks
□Respiratory Problems
□Rheumatic Fever
□Rheumatic Arthritis
□Seizures
□Sinus Problems
□Stomach Problems
□Stroke or TIA
□Thyroid Disease
□Tuberculosis
□Tumor
□Ulcer
□Other_____

Do you:	**Yes**	**No**
Smoke	□	□
Use smokeless tobacco	□	□

Have you taken any of the following Medications or therapies?

□ Actonel
□ Boniva
□ Fosamax
□ Skelid
□ Didronel
□ Reclast

□ I.V. Bisphophonate
□ Cortisone
□ Steroids
□ Tetracycline
□ Chemotherapy
□ Radiation Therapy
□ None of the above

Women: Are you pregnant or possibly pregnant? **□Yes** **□No**

I am allergic to the following medications:

I am allergic to the following foods:

Are you allergic to latex? **□Yes** **□No**

Medications you are taking:

Signature:	**Date:**

Dr. Karl I. Lutes