MEDICAL HEALTH HISTORY

PLEASE COMPLETE ALL INFORMATION - THANK YOU

PATIENT LAST NAME: _____ PATIENT FIRST NAME: _____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____ Physician's Phone Number _____

Have you had any serious illnesses or operations? Yes ❑ No ❑ If yes, please describe _____

Have you ever had a blood transfusion? Yes ❑ No ❑ If yes, give approximate dates _____

Medication History: ❑ None

Please list all current medications: _____

Allergies: ❑ None

List medication Allergies: _____

Latex: Yes ❑ No ❑

Other allergies: _____

Please check if you have/had:	Yes	No		Yes	No
Abnormal Bleeding	❑	❑	Hepatitis C	❑	❑
Alcohol Abuse	❑	❑	High Blood Pressure	❑	❑
Allergies	❑	❑	Joint Replacement	❑	❑
Anemia	❑	❑	Kidney Problems	❑	❑
Angina Pectoris	❑	❑	Liver Disease	❑	❑
Arthritis	❑	❑	Low Blood Pressure	❑	❑
Artificial Heart	❑	❑	Lupus	❑	❑
Asthma	❑	❑	Metastatic Cancer	❑	❑
Blood Transfusion	❑	❑	Multiple Myeloma	❑	❑
Cancer - Chemotherapy	❑	❑	Osteoporosis	❑	❑
Colitis	❑	❑	Pace Maker	❑	❑
Congenital Heart	❑	❑	Pagets Disease	❑	❑
Cosmetic Surgery	❑	❑	Pain in Jaw	❑	❑
Diabetes	❑	❑	Psychiatric Problems	❑	❑
Difficulty Breathing	❑	❑	Radiation Therapy	❑	❑
Drug Abuse	❑	❑	Seizures	❑	❑
Emphysema	❑	❑	Shingles	❑	❑
Epilepsy	❑	❑	Sickle Cell Disease	❑	❑
Fainting Spells	❑	❑	Sinus Problems	❑	❑
Frequent Headaches	❑	❑	Stroke	❑	❑
Glaucoma	❑	❑	Thyroid Problems	❑	❑
HIV + AIDS	❑	❑	Tuberculosis	❑	❑
Heart Attack	❑	❑	Ulcers	❑	❑
Heart Surgery	❑	❑	Venereal Disease	❑	❑
Hemophilia	❑	❑	Yellow Jaundice	❑	❑
Hepatitis A	❑	❑			
Hepatitis B	❑	❑			

	Yes	No
Bisphosphonate or Bone Density Therapy	❑	❑
Check box if you have taken: Aredia ❑ Zometa ❑		
If Yes, for how long? _____		
Have you had IV therapy for Multiple Myeloma or Metastatic Cancer or Pagets Disease?	❑	❑
Have you taken an oral bisphosphonate?	❑	❑
If Yes, which kind? _____		
And how long have you been on bisphosphonate therapy? _____		
Do you smoke or use tobacco?	❑	❑
Coumadin or other blood thinning medication?	❑	❑
If yes, are you required to have your INR monitored?	❑	❑
Females: Gynecological History		
Are you taking birth control pills?	❑	❑
If Yes, please list medications: _____		
Are you pregnant?	❑	❑
Are you nursing?	❑	❑
Do you take any over-the-counter medications, including vitamins?	❑	❑
If yes, please list: _____		

List any other medications that you are taking:

_____

_____

Are there any other medical conditions Dr. Evans needs to be aware of? _____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____