MEDICAL HISTORY OF PATIENT

1. Your current physical health is: ☐Good ☐Fair ☐Poor

2. Do you smoke or use tobacco in any other form? ☐Yes ☐No

3. Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐Yes ☐No
   * Which ones?

4. Have you ever taken Fosamax, or any other bisphophonate? ☐Yes ☐No

5. Have you ever taken Phen-Fen? ☐Yes ☐No

6. Are you under a physician's care now? ☐Yes ☐No

   If so, please give reason for treatment:

   Physician's Name: Telephone:

For Women :

7. Are you using a prescribed method of birth control? ☐Yes ☐No

8. Are you pregnant? ☐Yes ☐No
   Week #:

9. Have you ever had any of the following diseases or medical problems?

Y ☐ N ☐	Abnormal Bleeding	Y ☐ N ☐	Herpes / Fever Blisters
Y ☐ N ☐	Alcohol / Drug Abuse	Y ☐ N ☐	High Blood Pressure
Y ☐ N ☐	Anemia	Y ☐ N ☐	HIV+ / AIDS
Y ☐ N ☐	Arthritis	Y ☐ N ☐	Hospitalized for Any Reason
Y ☐ N ☐	Artificial Bones / Joints / Valves	Y ☐ N ☐	Kidney Problems
Y ☐ N ☐	Asthma	Y ☐ N ☐	Liver Disease
Y ☐ N ☐	Blood Transfusion	Y ☐ N ☐	Low Blood Pressure
Y ☐ N ☐	Cancer / Chemotherapy	Y ☐ N ☐	Lupus
Y ☐ N ☐	Colitis	Y ☐ N ☐	Mitral Valve Prolapse
Y ☐ N ☐	Congenital Heart Defect	Y ☐ N ☐	Osteoporosis / Paget's Disease
Y ☐ N ☐	Diabetes	Y ☐ N ☐	Pacemaker
Y ☐ N ☐	Difficulty Breathing	Y ☐ N ☐	Psychiatric Problems
Y ☐ N ☐	Emphysema	Y ☐ N ☐	Radiation Treatment
Y ☐ N ☐	Epilepsy	Y ☐ N ☐	Rheumatic / Scarlet Fever
Y ☐ N ☐	Fainting Spells	Y ☐ N ☐	Seizures
Y ☐ N ☐	Frequent Headaches	Y ☐ N ☐	Shingles
Y ☐ N ☐	Glaucoma	Y ☐ N ☐	Sickle Cell Disease/ Traits
Y ☐ N ☐	Hay Fever	Y ☐ N ☐	Sinus Problems
Y ☐ N ☐	Heart Attack	Y ☐ N ☐	Stroke
Y ☐ N ☐	Heart Murmur	Y ☐ N ☐	Thyroid Problems
Y ☐ N ☐	Heart Surgery	Y ☐ N ☐	Tuberculosis (TB)
Y ☐ N ☐	Hemophilia	Y ☐ N ☐	Ulcers
Y ☐ N ☐	Hepatitis	Y ☐ N ☐	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

10. Are you allergic to any of the following?

Y ☐ N ☐	Aspirin	Y ☐ N ☐	Erythromycin	Y ☐ N ☐	Tetracycline
Y ☐ N ☐	Codeine	Y ☐ N ☐	Latex	Y ☐ N ☐	Other
Y ☐ N ☐	Dental Anesthetics	Y ☐ N ☐	Penicillin		

Please list any other drugs/materials that you are allergic to: