

## Health History

### Have you had or suspected?

	Yes	No
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Ear Aches	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Biosphosphonate Therapy (i.e. zometa, fosamax, boniva)	<input type="checkbox"/>	<input type="checkbox"/>

### Have you ever taken?

Cortisone or Steroids	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants or Bloodthinners	<input type="checkbox"/>	<input type="checkbox"/>

### For Women Only:

Are you pregnant or is there  
a possibility of pregnancy

	Yes	No
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Liver Problem	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/Bladder Problem	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Prosthetic/Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Recent Medical Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Drug or Alcohol Problem	<input type="checkbox"/>	<input type="checkbox"/>
Smoking or Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>

### Are you Allergic to?

Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Any other Medications? If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>