MEDICAL HISTORY & INFORMATION

******Please mark (X) to all that that applies:***

( ) Are you now under the care of a Physician? _____

Physician Name: _____

( ) Are you in good health?

Date of last physical exam: _____

( ) Has there been any changes in your general health within the past year?

If yes, what condition is being treated? _____

( ) Have you had a serious illness, operation or been hospitalized in the past 5 years?

If yes, what was the illness or problem? _____

( ) Are you taking or have you recently taken any prescription or over the counter medicine?

If so, please list all, including vitamins, natural or herbal preparations

and/or diet supplements: _____

( ) Have you ever used **BISPHOSPHONATE MEDICATION**?

(Brand names ***Fosamax, Actonel, Atelvia, Didronel, Boniva, Aclasta***)

( ) Are you taking or scheduled to begin taking either of the medications for osteoporosis or Paget's disease?

( ) Were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Date treatment began: _____

( ) Do you use tobacco (smoking, snuff, chew, bidis)?

( ) Do you drink alcoholic beverages?

If yes, how much alcohol do you typically drink in a week? _____

( ) ***Allergies*** - Are you allergic to or have you had a reaction to any of the following;

Specify type of reaction.

( )	Local anesthetics	( )	Metals
( )	Aspirin	( )	Latex (rubber)
( )	Penicillin or other antibiotics	( )	Iodine
( )	Barbiturates, sedatives, or sleeping pills	( )	Hay fever/seasonal
( )	Sulfa drugs	( )	Animals
( )	Codeine or other narcotics	( )	Food

Others:

WOMEN ONLY Are you:

( ) Pregnant:

Number of weeks _____

( ) Taking birth control pills or hormonal replacement?

( ) Nursing?