Name			MEDICAL HISTORY					
Account No.			M	edical Alert				
Have you had any medical care w			two years?				Yes	No
	r druas	durina					Yes	No
•	-	-						
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?								No
Have you ever taken bone loss pr	eventio	on drugs	s such as Fosamax, Ad	ctonel, Boniva or othe			Yes	No
Are you aware of having an allerg	ic (or a	dverse	reaction to any subst	ance or medication?			Yes	No
							Yes	No
Indicate which of the following yo	u have	had, or	have at present. Circ	le "yes" or "no" to ea	ch item.			
Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle)	Yes	No
					No			No
	Yes	No			No			No
•	Yes	No	•		No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Yellow Jaundice	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/H	ives Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Cancer	Yes	No
Have you lost or gained more tha	n 10 po	ounds ir	the past year?				Yes	No
								No
Do you use birth control prescript	tions?.						Yes	No
		!						
understand the above infor nswered all questions to th sk the respective health ca ny change in my health or r	e bes re pro	t of m	y knowledge. Sho or agency, who m	uld further inform	nation I		ermiss	ion to
	Have you had any medical care we Describe Have you taken any medication of If yes, please list name and dosage Are you currently taking any medication of If yes, please list name and dosage Have you ever taken bone loss professed in the professed in the yes, please list name and dosage Are you aware of having an allergous If yes, please specify Have you been a patient in the house to have you been a patient in the house to have you been a patient in the house to have you been a patient in the house to have you been a patient in the house to have you been a patient in the house to have you been a patient in the house to have you been a patient in the house to have you had any If yes, please list: Women: Are you pregnant or the possible in the you have or have you had any If yes, please list: Women: Are you pregnant or the possible in the you pregnant or the possible in the you pregnant or the year.	Have you had any medical care within the Describe	Have you had any medical care within the past Describe Have you taken any medication or drugs during If yes, please list name and dosage Are you currently taking any medication, drugs, If yes, please list name and dosage Have you ever taken bone loss prevention drugs If yes, please list name and dosage Are you aware of having an allergic (or adverse If yes, please specify Have you been a patient in the hospital during the Indicate which of the following you have had, or Chest Pain	Have you had any medical care within the past two years?	Have you had any medical care within the past two years? Have you taken any medication or drugs during the past two years? If yes, please list name and dosage Are you currently taking any medication, drugs, pills or herbal remedies, including regular of lifyes, please list name and dosage Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or othe lifyes, please list name and dosage Are you aware of having an allergic (or adverse) reaction to any substance or medication? If yes, please specify Have you been a patient in the hospital during the past five years? Indicate which of the following you have had, or have at present. Circle "yes" or "no" to ear the following you have had, or have at present. Circle "yes" or "no" to ear the following you have had, or have at present. Circle "yes" or "no" to ear the following you have had, or have at present. Circle "yes" or "no" to ear the following you have had, or have at present. Circle "yes" or "no" to ear the following you have had, or have at present. Circle "yes" or "no" to ear the following you have had, or have at present. 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If yes, please list name and dosage Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bispholication of the past gradient of the following you have had, or have at present. Circle "yes" or "no" to each item. Heart (Surgery, Disease, Attack) Yes No Ulcers	Have you had any medical care within the past two years? Describe Have you taken any medication or drugs during the past two years? If yes, please list name and dosage Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? If yes, please list name and dosage Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? If yes, please list name and dosage Are you aware of having an allergic (or adverse) reaction to any substance or medication? If yes, please specify Have you been a patient in the hospital during the past five years? Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item. Heart (Surgery, Disease, Attack). Yes No Ulcers. Yes No Hepatitis A B C (circle). Chest Pain. Yes No Diabetes. Yes No Venereal Disease Yes No Venereal Disease High/Low Blood Pressure Yes No Glaucoma. Yes No Al.D.S./H.I.V. Positive Heart Murmur. Yes No Glaucoma. Yes No Cod Sores/Fever Blisters. High/Low Blood Pressure Yes No Contact lenses Yes No Hemophilia Arthritis/Rheumatism Yes No Chronic Cough Yes No Sickle Cell Disease Arthritis/Rheumatism Yes No Asthma Yes No Rever/Allergy/Hives Yes No Revolus/Anxious Arthritis/Rheumatism Yes No Adsthma Yes No Neurological Disorders Stroke Yes No Raciation Therapy Yes No Neurological Disorders Stroke Yes No Raciation Therapy Yes No Neurological Care. Cortisone Medicine Yes No Raciation Therapy Yes No Neurological Care. Stroke Yes No Raciation Therapy Yes No Revous/Anxious Arthritis/Repertant or think you could be pregnant? Yes Months No Nursing? Yes No Nursing? Yes No Nursing? Yes No Nursing? Yes No Cancer Women: Are you pregnant or think you could be pregnant? Women: Are you pregnant or think you could be pregnant? Yes Months	Have you had any medical care within the past two years? Pescribe Have you taken any medication or drugs during the past two years? Yes If yes, please list name and dosage Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? Yes If yes, please list name and dosage Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? Yes If yes, please list name and dosage Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes If yes, please specify Have you been a patient in the hospital during the past five years? Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item. Heart (Surgery, Disease, Attack) Yes No Diabetes Yes No Diabetes Yes No Venereal Disease Yes Congenital Heart Disease Yes No Diabetes Yes No Cold Sores/Fever Blisters Yes High/Low Blood Pressure Yes No Contact lenses Yes No Chronic Cough Yes No Brujesemaker Yes No Bruise Easily Yes No Bruise Easily Yes Arthritis/Rheumatism Yes No Diabetes Yes No Cold Sores/Fever Blisters Yes Ro Ritrial Valve/Pacemaker Yes No Diabetes Yes No Diabete

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