



Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses? .....	Yes	No	DK	Do you use controlled substances (drugs)?.....	Yes	No	DK
<b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? .....				Do you use tobacco (smoking, snuff, chew, bidis)? .....			
Date: _____ If yes, have you had any complications?.....				If so, how interested are you in stopping? .....			

(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? .....	Yes	No	DK	Do you drink alcoholic beverages? .....	Yes	No	DK
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?.....				If yes, how much alcohol did you drink in the last 24 hours? .....			
Date Treatment began: _____				If yes, how much do you typically drink in a week? .....			

**WOMEN ONLY** Are you:

Pregnant? .....	Yes	No	DK
Number of weeks: _____			
Taking birth control pills or hormonal replacement?.....			
Nursing? .....			

**Allergies** - Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction.

Local anesthetics .....	Yes	No	DK
Aspirin .....			
Penicillin or other antibiotics .....			
Barbiturates, sedatives, or sleeping pills .....			
Sulfa drugs .....			
Codeine or other narcotics .....			

Metals .....	Yes	No	DK
Latex (rubber) .....			
Iodine .....			
Hay fever/seasonal .....			
Animals .....			
Food .....			
Other .....			

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve .....	Yes	No	DK	Autoimmune disease .....	Yes	No	DK
Previous infective endocarditis .....				Rheumatoid arthritis .....			
Damaged valves in transplanted heart .....				Systemic lupus erythematosus .....			
Congenital heart disease (CHD)				Asthma .....			
Unrepaired, cyanotic CHD .....				Bronchitis .....			
Repaired (completely) in last 6 months .....				Emphysema .....			
Repaired CHD with residual defects .....				Sinus trouble .....			
				Tuberculosis .....			

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Cardiovascular disease .....	Yes	No	DK	Mitral valve prolapse .....	Yes	No	DK
Angina .....				Pacemaker .....			
Arteriosclerosis .....				Rheumatic fever .....			
Congestive heart failure .....				Rheumatic heart disease .....			
Damaged heart valves .....				Abnormal bleeding .....			
Heart attack .....				Anemia .....			
Heart murmur .....				Blood transfusion .....			
Low blood pressure .....				If yes, date: _____			
High blood pressure .....				Hemophilia .....			
Other congenital heart defects .....				AIDS or HIV infection .....			
				Arthritis .....			

Cancer/Chemotherapy/ Radiation Treatment .....	Yes	No	DK	Hepatitis, jaundice or liver disease .....	Yes	No	DK
Chest pain upon exertion .....				Epilepsy .....			
Chronic pain .....				Fainting spells or seizures .....			
Diabetes Type I or II .....				Neurological disorders .....			
Eating disorder .....				If yes, specify: _____			
Malnutrition .....				Sleep disorder .....			
Gastrointestinal disease .....				Mental health disorders .....			
G.E. Reflux/persistent heartburn .....				Specify: _____			
Ulcers .....				Recurrent Infections .....			
Thyroid problems .....				Type of infection: _____			
Stroke .....				Kidney problems .....			
Glaucoma .....				Night sweats .....			
				Osteoporosis .....			
				in neck .....			
				Severe headaches/ migraines .....			
				Severe or rapid weight loss .....			
				Sexually transmitted disease .....			
				Excessive urination .....			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any disease, condition, or problem not listed above that you think I should know about? .....

Please explain: \_\_\_\_\_

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_

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