

Medical Information 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)	Yes	No	DK		Yes	No	DK
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date Treatment began:				If yes, how much alcohol did you drink in the last 24 hours?			
				If yes, how much do you typically drink in a week?			
				WOMEN ONLY Are you:			
				Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Number of weeks:			
				Taking birth control pills or hormonal replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: If yes, have you had any complications?

Allergies - Are you allergic to or have you had a reaction to:	Yes	No	DK		Yes	No	DK
To all yes responses, specify type of reaction.				Metals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Yes	No	DK	Yes	No	DK	Yes	No	DK	Yes	No	DK				
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date:				Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:			
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection:			
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Empysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/				Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, Specify:							

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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