

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

<p>(Check DK if you Don't Know the answer to the question)</p> <p>Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Date Treatment began: _____</p>	<p>Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Number of weeks: _____ Taking birth control pills or hormonal replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes No DK
Date: _____ If yes, have you had any complications? Yes No DK

<p>Allergies - Are you allergic to or have you had a reaction to: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Metals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Latex (rubber) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Iodine _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Hay fever/seasonal _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Animals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Food _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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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					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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:_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify:_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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:_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	<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"/>	erythematosus.....	<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"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/ migraines.....
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss..
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease..
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart defects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination.....
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/ Radiation Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<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:_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No DK

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? Yes No DK
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: _____

