

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

<b>(Check DK if you Don't Know the answer to the question)</b>			<b>Yes No DK</b>				<b>Yes No DK</b>
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"/>
<b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? .....			<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"/>
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? .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you drink alcoholic beverages? .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				If yes, how much alcohol did you drink in the last 24 hours? _____			
				If yes, how much do you typically drink in a week? _____			
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"/>	<b>WOMEN ONLY</b> Are you:			
Date Treatment began: _____				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"/>
<b>Allergies</b> - Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.			<b>Yes No DK</b>				<b>Yes No DK</b>
Local anesthetics .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Metals .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Aspirin .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Latex (rubber) .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Penicillin or other antibiotics .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Iodine .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hay fever/seasonal .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sulfa drugs .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Animals .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Codeine or other narcotics .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Food .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Other .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.</b>							
			<b>Yes No DK</b>				<b>Yes No DK</b>
Artificial (prosthetic) heart valve .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Autoimmune disease .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Previous infective endocarditis .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged valves in transplanted heart .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Systemic lupus erythematosus .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart disease (CHD)				Asthma .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Unrepaired, cyanotic CHD .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired (completely) in last 6 months .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Emphysema .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired CHD with residual defects .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus trouble .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Tuberculosis .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>				Cancer/Chemotherapy/ Radiation Treatment .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Chest pain upon exertion .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Chronic pain .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Diabetes Type I or II .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Eating disorder .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Malnutrition .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Gastrointestinal disease .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				G.E. Reflux/persistent heartburn .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Ulcers .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Thyroid problems .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Stroke .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Glaucoma .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Hepatitis, jaundice or liver disease .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Epilepsy .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Fainting spells or seizures .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Neurological disorders .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				If yes, specify: _____			
				Sleep disorder .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Mental health disorders .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Specify: _____			
				Recurrent Infections .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Type of infection: _____			
				Kidney problems .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Night sweats .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Osteoporosis .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Persistent swollen glands in neck .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Severe headaches/ migraines .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Severe or rapid weight loss .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Sexually transmitted disease .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Excessive urination .....			<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? .....							
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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