

Medical Information Please . . . (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
Joint Replacement. 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?			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax [®]) or risedronate (Actonel [®]) for osteoporosis or Paget's disease?				(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?				Do you drink alcoholic beverages?.....			
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?

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	Metals	Yes	No	DK
Aspirin				Latex (rubber)			
Penicillin or other antibiotics				Iodine			
Barbiturates, sedatives, or sleeping pills				Hay fever/seasonal			
Sulfa drugs				Animals			
Codeine or other narcotics				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			
				Persistent swollen glands 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: _____
