



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

<p><b>(Check DK if you Don't Know the answer to the question)</b></p> <p>Do you wear contact lenses? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p><b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date: _____ If yes, have you had any complications? _____</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 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? (Check 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><b>WOMEN ONLY</b> 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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<p><b>Allergies</b> - Are you allergic to or have you had a reaction to: <b>Yes No DK</b></p> <p>To all <b>yes</b> 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><b>Yes No DK</b></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
Artificial (prosthetic) heart valve ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK				Autoimmune disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
Previous infective endocarditis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK				Rheumatoid arthritis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
Damaged valves in transplanted heart ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK				Systemic lupus erythematosus ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
Congenital heart disease (CHD)				Asthma ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
Unrepaired, cyanotic CHD ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK				Bronchitis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
Repaired (completely) in last 6 months ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK				Emphysema ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
Repaired CHD with residual defects ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK				Sinus trouble ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>				Tuberculosis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Cancer/Chemotherapy/ Radiation Treatment ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Chest pain upon exertion ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Chronic pain ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Diabetes Type I or II ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Eating disorder ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Malnutrition ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Gastrointestinal disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				G.E. Reflux/persistent heartburn ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Ulcers ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Thyroid problems ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Stroke ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Glaucoma ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Hepatitis, jaundice or liver disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Epilepsy ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Fainting spells or seizures ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Neurological disorders ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				If yes, specify: _____			
				Sleep disorder ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Mental health disorders ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Specify: _____			
				Recurrent Infections ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Type of infection: _____			
				Kidney problems ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Night sweats ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Osteoporosis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Persistent swollen glands in neck ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Severe headaches/ migraines ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Severe or rapid weight loss ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Sexually transmitted disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			
				Excessive urination ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			

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: \_\_\_\_\_  
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