



# 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"/>			
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"/>	If yes, how much alcohol did you drink in the last 24 hours? _____								
Date Treatment began: _____						If yes, how much do you typically drink in a week? _____								
<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"/>			
			<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>				<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"/>			
			<b>Yes No DK</b>				<b>Yes No DK</b>				<b>Yes No DK</b>			
Cardiovascular disease. ....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Angina .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Arteriosclerosis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Congestive heart failure .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Damaged heart valves .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart attack .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart murmur .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Low blood pressure .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
High blood pressure .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Other congenital heart defects .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<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"/>	Recurrent Infections .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Specify: _____						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? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
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? .....												<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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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