

**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><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><b>Allergies.</b> Are you allergic to or have you had a reaction to: Yes No DK 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 Aspirin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Penicillin or other antibiotics _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Barbiturates, sedatives, or sleeping pills _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Sulfa drugs _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Codeine or other narcotics _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</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><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> <p>Metals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Latex (rubber) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Iodine _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Hay fever/seasonal _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Animals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Food _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
--	---

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

<p>Artificial (prosthetic) heart valve..... <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 Damaged valves in transplanted heart ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Congenital heart disease (CHD) Unrepaired, cyanotic CHD ..... <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 Repaired CHD with residual defects..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p><i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i></p> <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <p>Cardiovascular disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Angina..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Arteriosclerosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Congestive heart failure.. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Damaged heart valves..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Heart attack..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Heart murmur ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Low blood pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK High blood pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Other congenital heart defects..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> </td> <td style="width:50%; vertical-align: top;"> <p>Mitral valve prolapse ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Pacemaker ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Rheumatic fever ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Rheumatic heart failure... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Abnormal bleeding..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Anemia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Blood transfusion ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, date: _____ Hemophilia..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK AIDS or HIV infection ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Arthritis..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> </td> </tr> </table>	<p>Cardiovascular disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Angina..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Arteriosclerosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Congestive heart failure.. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Damaged heart valves..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Heart attack..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Heart murmur ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Low blood pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK High blood pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Other congenital heart defects..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Mitral valve prolapse ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Pacemaker ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Rheumatic fever ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Rheumatic heart failure... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Abnormal bleeding..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Anemia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Blood transfusion ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, date: _____ Hemophilia..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK AIDS or HIV infection ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Arthritis..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Autoimmune disease..... <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 Systemic lupus erythematosus. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Asthma ..... <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 Emphysema..... <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 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</p> <p>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</p>
<p>Cardiovascular disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Angina..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Arteriosclerosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Congestive heart failure.. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Damaged heart valves..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Heart attack..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Heart murmur ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Low blood pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK High blood pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Other congenital heart defects..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Mitral valve prolapse ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Pacemaker ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Rheumatic fever ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Rheumatic heart failure... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Abnormal bleeding..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Anemia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Blood transfusion ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, date: _____ Hemophilia..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK AIDS or HIV infection ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Arthritis..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>		

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: \_\_\_\_\_

**PLEASE LIST MEDICATIONS YOU TAKE:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_