



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

Do you use controlled substances (drugs)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use tobacco (smoking, snuff, chew, bidis)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED
<b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ If yes, have you had any complications? _____	Do you drink alcoholic beverages? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____
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	<b>WOMEN ONLY</b> Are you: Pregnant? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Number of weeks: _____ Taking birth control pills or hormonal replacement? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Nursing? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
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 Date Treatment began: _____	

<b>Allergies</b> - Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.	Yes No <input type="checkbox"/> <input type="checkbox"/> Metals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Local anesthetics _____ <input type="checkbox"/> <input type="checkbox"/> Latex (rubber) _____ <input type="checkbox"/> <input type="checkbox"/> Aspirin _____ <input type="checkbox"/> <input type="checkbox"/> Iodine _____ <input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics _____ <input type="checkbox"/> <input type="checkbox"/> Hay fever/seasonal _____ <input type="checkbox"/> <input type="checkbox"/> Barbiturates, sedatives, or sleeping pills _____ <input type="checkbox"/> <input type="checkbox"/> Animals _____ <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs _____ <input type="checkbox"/> <input type="checkbox"/> Food _____ <input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics _____ <input type="checkbox"/> <input type="checkbox"/> Other _____ <input type="checkbox"/> <input type="checkbox"/>
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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		Yes	No	Yes	No	
Artificial (prosthetic) heart valve .....	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis .....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart .....	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus .....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures .....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)			Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders .....	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD .....	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis .....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify: _____		
Repaired (completely) in last 6 months .....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder .....	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects .....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders .....	<input type="checkbox"/>	<input type="checkbox"/>
			Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____		
			Cancer/Chemotherapy/			Recurrent Infections .....	<input type="checkbox"/>	<input type="checkbox"/>
			Radiation Treatment .....	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection _____		
			Chest pain upon exertion .....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems .....	<input type="checkbox"/>	<input type="checkbox"/>
			Chronic pain .....	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats .....	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes Type I or II .....	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis .....	<input type="checkbox"/>	<input type="checkbox"/>
			Eating disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands		
			Malnutrition .....	<input type="checkbox"/>	<input type="checkbox"/>	in neck .....	<input type="checkbox"/>	<input type="checkbox"/>
			Gastrointestinal disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/		
			G.E. Reflux/persistent			migraines .....	<input type="checkbox"/>	<input type="checkbox"/>
			heartburn .....	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss .....	<input type="checkbox"/>	<input type="checkbox"/>
			Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease .....	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid problems .....	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination .....	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>			
			Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>			

*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

	Yes	No		Yes	No
Cardiovascular disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis .....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever .....	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure .....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart Valves .....	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack .....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion .....	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date: _____		
High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia .....	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart			AIDS or HIV infection .....	<input type="checkbox"/>	<input type="checkbox"/>
defects .....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....  Yes  No

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  
 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 office use only**

Comments: \_\_\_\_\_  
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