

Medical Information Please mark (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) | | | Yes No DK | | | | Yes No DK | | | | |
| 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"/> |
| Joint Replacement. 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? _____ | | | | | |
| Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction. | | | Yes No DK | | | | Yes No DK | | | | |
| 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"/> |
| 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 | | | | Yes No DK |
| 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"/> |
| | | | Yes No DK | | | | Yes No DK | | | | Yes No DK |
| 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"/> |
| 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"/> | | | | <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? | | | | | | | | | | | |
| 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: _____

