Health History Form

ADA American Dental Association®

America's leading advocate for oral health

SSE or Patient ID. Emergency Contact: Relationship: Home Phone: include ower code (1) If you are completing this form for another person, what is your relationship to that person? Your home Restrowthp Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) Active Tuberculosis (Prestriett cough greater than a 3 week duration. Cough that produces blood. Been exposed to anyone with tuberculosis. If you are to any of the 4 items above, please stop and return this form to the receptionist. Dental Information Please mark (X) your responses to the following questions. Ver No DK Do you gruins bleed when you brush or floss? Are you treth sentitive to cold, hot, sweets or pressure? Do you have earaches or neck pains? Do you ware the desired in active recreational activities? Have you even had a serious impay to your head or mouth? Do you ware have earaches or neck pains? What was come at that time? Have you have earaches or neck pains? If yes, what was the lines or pr	
Name: Name Phone: Include over code Subiners/Cell Phone: Include over code Code	ere may be
Address City State: Zep: Address City State: Zep: Address City State: Zep: Address Description: Height: Weight: Date of Birth: State: Zep: State: State: State: State: State: Zep: Address Meight: Date of Birth: State:	ode
Occupation: Height: Weight: Date of Birth: S See or Patient ID: Emergency Contact: Relationship: Home Phone: incluse one cool () or but for another person, what is your relationship to that person? Now Young Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) Active Tiberculosis Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) Active Tiberculosis Deeperstent cough greater than a 3 week duration Cough that produces blood. Been exposed to anyone with tuberculosis. If you answer yes to any of the A items above, please stop and return this form to the receptionist. Dental Information Please mark (X) your response to the following questions. Yes No DK Do your gums bleed when you brush or floss? Are your testh sensitive to cold, hot, sweets or pressure? Do you have earaches or neck pains? Dental Information Please mark (X) your response to the following questions. Yes No DK The No DK Do you have earaches or neck pains? We not not pain a successful to the pain a successful to th	
Occupation: Height: Weight: Date of Birth: S SS# or Patient ID: Emergency Contact: Relationship: Home Prione: include ores code () If you are completing this form for another person, what is your relationship to that person? The Vision of the Completing this form for another person, what is your relationship to that person? The Vision of the Completing this form for another person, what is your relationship to that person? The Vision of the Completing this form for another person, what is your relationship to that person? The Vision of the Completing this form for another person, what is your relationship to that person? The Vision of the Completing this form for another person, what is your relationship to that person? The Vision of the Completing this form to the person of the Completing this produces blood Been exposed to any pare with fuberculosis. If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Dental Information Please mark (X) your responses to the following questions. Yes No DK Do you have any cicking, popping or discomfort in the jaw? As your teeth sensitive to cold, not, sweets or pressure? Do you have any cicking, popping or discomfort in the jaw? Syour mouth dry? Have you had any problems associated with previous dental treatment? Do you have any cicking, popping or discomfort in the jaw? Have you had any problems associated with previous dental treatment? Do you purpose the active recreational activities? Have you had any problems associated with previous dental treatment? Do you wear dentures or partials? Have you had any problems associated with previous dental treatment? Do you wear dentures or partials? Do you be the denture or partials? Have you had any problems associated with previous dental treatment? Do you be the dentures or partials? Do you be an or the following diseases or problems. Yes No DK What is the resen in a cicking problems. Phone: Include area code: (1) Have you wear dentures or partials? Wh	
Occupation: Height: Weight: Date of Birth: S SS# or Patient ID: Emergency Contact: Relationship: Home Prione: include ores code () If you are completing this form for another person, what is your relationship to that person? The Vision of the Completing this form for another person, what is your relationship to that person? The Vision of the Completing this form for another person, what is your relationship to that person? The Vision of the Completing this form for another person, what is your relationship to that person? The Vision of the Completing this form for another person, what is your relationship to that person? The Vision of the Completing this form for another person, what is your relationship to that person? The Vision of the Completing this form to the person of the Completing this produces blood Been exposed to any pare with fuberculosis. If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Dental Information Please mark (X) your responses to the following questions. Yes No DK Do you have any cicking, popping or discomfort in the jaw? As your teeth sensitive to cold, not, sweets or pressure? Do you have any cicking, popping or discomfort in the jaw? Syour mouth dry? Have you had any problems associated with previous dental treatment? Do you have any cicking, popping or discomfort in the jaw? Have you had any problems associated with previous dental treatment? Do you purpose the active recreational activities? Have you had any problems associated with previous dental treatment? Do you wear dentures or partials? Have you had any problems associated with previous dental treatment? Do you wear dentures or partials? Do you be the denture or partials? Have you had any problems associated with previous dental treatment? Do you be the dentures or partials? Do you be an or the following diseases or problems. Yes No DK What is the resen in a cicking problems. Phone: Include area code: (1) Have you wear dentures or partials? Wh	
If you are completing this form for another person, what is your relationship to that person? **Relationship** Home Phone: include one cook**	Sex: M
If you are completing this form for another person, what is your relationship to that person? The Name Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) Active Tuberculous. Persistent cough greater than a 3 week duration. Cough that produces blood. Been exposed to anyone with tuberculouss If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Dental Information Please mark (X) your responses to the following questions. Yes No DK Do you guns bleed when you brush or floss? Are you reteth sensitive to cold, hot, sweets or pressure? Do you have earaches or neck pains? Are you the sensitive to cold, hot, sweets or pressure? Do you have only clicking, popping or discomfort in the jaw? By your would rely? Have you had any periodontal (gum) treatments? Do you have sensor ruleters in your mouth? Do you wear dentures or partials? Have you wear dentures or partials? What is the reason for your dental visit today? Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Have you had a serious illness, operation or been hospitalized in the past 5 years? Have you had a serious illness, operation or been hospitalized in the past 5 years? Have you have serious liness, operation or been hospitalized in the past 5 years? Affection over the courter medicine(s)? Are you taking or have you recently taken any prescription or over the courter medicine(s)? Are you taking or have you recently taken any prescription and/or deletary supplements: If yes, what	
Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) Active Tuberculosis Persistent cough greater than a 3 week duration. Cough that produces blood. Been exposed to anyone with tuberculosis. If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Dental Information Please mark (X) your responses to the following questions. Yes No DK Do you gums bleed when you brush or floss? Yes No DK Do you have earaches or neck pains? Do you have earaches or neck pains? Do you have or yind your teeth? Do you have sores or ulcers in your mouth? Have you ure had any periodontal (gum) treatments? Have you what of orthodontic (thraces) treatment? Do you have sores or ulcers in your mouth? Have you what day problems associated with previous dental treatment? Do you have sores or ulcers in your mouth? Have you what of orthodontic (thraces) treatment? Do you participate in active recreational activities? Have you were destinated or include the serious injury to your head or mouth? Date of your last clarited exam: What was done at that time? Are you currently experiencing dental pain or discomfort? Date of last dental x-rays: What is the reason for your dental visit today? Medical Information Please mark (X) your response to indicate if you have or hove not had any of the fallowing diseases or problems. Yes No DK Are you now under the care of a physician? Phone: Include areas code () Yes No DK Are you now under the care of a physician? Phone: Include areas code () Yes, No DK Are you now under the care of a physician? Are you in good health? Has there been any change in your general health within the past year? If yes, what condition is being treated?	de area code
Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) Active Tuberculosis Persistent cough greater than a 3 week duration. Cough that produces blood. Been exposed to anyone with tuberculosis. If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Dental Information Please mark (X) your responses to the following questions. Yes No DK Do you gums bleed when you brush or floss? Yes No DK Do you have earaches or neck pains? Do you have earaches or neck pains? Do you have or yind your teeth? Do you have sores or ulcers in your mouth? Have you ure had any periodontal (gum) treatments? Have you what of orthodontic (thraces) treatment? Do you have sores or ulcers in your mouth? Have you what day problems associated with previous dental treatment? Do you have sores or ulcers in your mouth? Have you what of orthodontic (thraces) treatment? Do you participate in active recreational activities? Have you were destinated or include the serious injury to your head or mouth? Date of your last clarited exam: What was done at that time? Are you currently experiencing dental pain or discomfort? Date of last dental x-rays: What is the reason for your dental visit today? Medical Information Please mark (X) your response to indicate if you have or hove not had any of the fallowing diseases or problems. Yes No DK Are you now under the care of a physician? Phone: Include areas code () Yes No DK Are you now under the care of a physician? Phone: Include areas code () Yes, No DK Are you now under the care of a physician? Are you in good health? Has there been any change in your general health within the past year? If yes, what condition is being treated?	
Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) Active Tuberculosis Peresistent cough greater than a 3 week duration. Cough that produces blood. Been exposed to anyone with tuberculosis If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Dental Information Please mark (X) your responses to the following questions. Ves No DK Do your gums bleed when you brush or floss? Are your teeth sensitive to cold, hot, sweets or pressure? Do you have any cicking, popping or discomfort in the jaw? By our mouth dry? Do you brus or grind your teeth? By our mouth dry? Do you brus or grind your teeth? By our mouth dry? Do you have any cicking, popping or discomfort in the jaw? Do you brus or grind your teeth? Do you ward dentures or partala? Do you participate in active recreational activities? It was you had any prolibens associated with previous dental treatment? Do you participate in active recreational activities? Do you dist dental exam: What was done at that time? Do you find bottled or filtered water? If yes, how often? (Check one) DallUr / WEEKLY / OCCASIONALLY Are you currently experiencing dental pain or discomfort? Date of jour last dental x-rays: What is the reason for your dental visit today? What is the reason for your dental visit today? What is the reason for your dental visit today? Are you now under the care of a physician? Phone: Include area code If yes, what was the illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? Are you in good health? Has there been any change in your general health within the past year? If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:	
Active Tuberculosis Persistent Cough greater than a 3 week duration Cough that produces blood. Been exposed to anyone with tuberculosis. If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Dental Information Please mark (X) your responses to the following questions. Yes No DK Do your gums bleed when you brush or floss? Are your teeth sensitive to cold, hot, sweets or pressure? Do you have earaches or neck pains? Do you have any clicking, popping or discomfort in the jaw? Do you have not your deeth? Have you had any periodontal (gum) treatments? Do you bad any prolems associated with previous dental treatment? Do you wear dentures or partials? Have you had any prolems associated with previous dental treatment? Do you wear dentures or partials? Wear you or had a serious injury to your head or mouth? Date of your last dental x-rays: What is the reason for your dental visit today? Wear you on offer (Check one) Dality to your head or mouth? Date of your last dental x-rays: What is the reason for your dental visit today? Wear you wear a feet of your your dental visit today? Wear you wear a feet of your your your your your your your your	Yes No
Persistent cough greater than a 3 week duration Cough that produces blood Been exposed to anyone with tuberculosis If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Dental Information Please mark (X) your responses to the following questions. Yes No DK Do your gums bleed when you brush or floss? Are your teeth sensitive to cold, not, sweets or pressure? Do you have any cicking, popping or discomfort in the jaw? Do you have any cicking, popping or discomfort in the jaw? Do you have sores or ulcers in your mouth? Have you had any periodontal (gum) treatments? Do you have sores or ulcers in your mouth? Do you wear dentures or partials? Have you were had orthodontic (braces) treatment? Do you wear dentures or partials? Have you were had orthodontic (braces) treatment? Do you wear dentures or partials? Have you were had a serious injury to your head or mouth? Do you drink bottled or filtered water? Date of your last dental exam. What was done at that time? Are you currently experiencing dental pain or discomfort? Date of fast dental x-rays: What is the reason for your dental visit today? What is the reason for your dental visit today? What is the reason for your dental visit today? What is the reason for your dental visit today? What is the reason for your dental visit today? Are you now under the care of a physician? Phone: include area code () Are you taking or have you recently taken any prescription or over the courter medicine(s)? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the courter medicine(s)? If yes, what condition is being treated?	
Geen exposed to anyone with tuberculosis If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. Dental Information Please mark (X) your responses to the following questions. Yes No DK Do your gums bleed when you brush or floss? Are your teeth sensitive to cold, hot, sweets or pressure? Do you have earaches or neck pains? Do you have earaches or neck pains? Do you have any cicking, popping or discomfort in the jaw? Do you have any cicking, popping or discomfort in the jaw? Do you have sore or ulcers in your mouth? Do you have sore or ulcers in your mouth? Do you wave or had orthodontic (braces) treatment? Have you even had orthodontic (braces) treatment? Do you participate in active recreational activities? Have you had any problems associated with previous dental treatment? Do you participate in active recreational activities? Have you ever had a serious injury to your head or mouth? Do you drink bottled or filtered water? Date of your last dental exam: What was done at that time? Are you currently experiencing dental pain or discomfort? Date of last dental x-rays: What is the reason for your dental visit today? Wedical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Are you now under the care of a physician? Phone: Include area code () Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? If so, please ist all, including vitamins, natural or herbal preparations and/or dietary supplements: If yes, what condition is being treated?	
Been exposed to anyone with tuberculosis If you answer yes to any of the 4 Items above, please stop and return this form to the receptionist. Dental Information Please mark (X) your responses to the following guestions. Ves No DK Do you have earaches or neck pains? Do you have earaches or neck pains? Do you have any clicking, popping or discomfort in the jaw? Do you have any clicking, popping or discomfort in the jaw? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you arising at a clicking, popping or discomfort in the jaw? By our home water supply fluoridated? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you have sores or ulcers in your mouth? Do you participate in active recreational activities? Have you ever had a serious injury to your head or mouth? Date of your last dental exam. What was done at that time? What is the reason for your dental visit today? What is the reason for your dental visit today? West of DK West of DK Have you had a serious illiness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:	
Dental Information Please mark (X) your responses to the following questions. Yes No DK Do your gums bleed when you brush or floss?	
Dental Information Please mark (X) your responses to the following questions. Yes No DK Do your gums bleed when you brush or floss? Are your teeth sensitive to cold, hot, sweets or pressure? Is your mouth dry? Do you have any clicking, popping or discomfort in the jaw? Do you brush or grind your ceeth? Do you brush or grind your ceeting or purshis? Do you brush or grind your ceeth? Do you brush or grind your ceeting or purshis? Do you wear dentures or partials? Do you wear dentures or partials? Do you wear dentures or partials? Do you participate in active recreational activities? Have you ever had a serious injury to your head or mouth? Date of your last dental exam. What was done at that time? Are you currently experiencing dental pain or discomfort? Date of last dental x-rays: What is the reason for your dental visit today? How do you feel about your smile? Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? If yo, please list all, including vitamins, natural	0 0
Ves No DK Do your gums bleed when you brush or floss?	
Ves No DK Do your gums bleed when you brush or floss?	
Do your gums bleed when you brush or floss?	
Are you currently experiencing dental pain or discomfort? What is the reason for your dental visit today? Who do you feel about your smile? We you now under the care of a physician? Phone: Include area code () Are you now under the care of a physician? Phone: Include area code () Are you ing good health? Are you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problems. Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you taking or have you counter medicine(s)? Are you taking or have you counter medicine(s)? Are you taking or have you recently taken any prescription and/or dietary supplements:	Yes No I
Are you currently experiencing dental pain or discomfort? What is the reason for your dental visit today? Who do you feel about your smile? We you now under the care of a physician? Phone: Include area code () Are you now under the care of a physician? Phone: Include area code () Are you ing good health? Are you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problems. Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you taking or have you counter medicine(s)? Are you taking or have you counter medicine(s)? Are you taking or have you recently taken any prescription and/or dietary supplements:	
Is your mouth dry? Do you brux or grind your teeth?	
Have you had any periodontal (gum) treatments?	
Have you ever had orthodontic (braces) treatment?	
Have you had any problems associated with previous dental treatment? Do you participate in active recreational activities? Have you ever had a serious injury to your head or mouth? Do you drink bottled or filtered water? Date of your last dental exam: What was done at that time? Date of your last dental exam: What was done at that time? Date of last dental x-rays: Date of last dental x-rays: What is the reason for your dental visit today? Date of last dental x-rays: Date of last dental x	
Is your home water supply fluoridated? Have you ever had a serious injury to your head or mouth? Date of your last dental exam: What was done at that time? Date of your last dental exam: What was done at that time? Date of last dental x-rays: Date of last dental x-r	
Do you drink bottled or filtered water? Date of your last dental exam: What was done at that time? Date of last dental exam: What was done at that time? Date of last dental exam: What was done at that time? Date of last dental x-rays: D	
If yes, how often? (Check one:) DAILY WEEKLY / OCCASIONALLY Are you currently experiencing dental pain or discomfort? Date of last dental x-rays: What is the reason for your dental visit today? How do you feel about your smile? Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Are you now under the care of a physician? Phone: Include area code In the past 5 years? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you in good health? If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: If yes, what condition is being treated?	U U
Are you currently experiencing dental pain or discomfort?	
What is the reason for your dental visit today? Medical Information Please mark (X) your response to Indicate if you have or have not had any of the following diseases or problems. Yes No DK Are you now under the care of a physician? Phone: Include area code () Address/City/State/Zip: Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you in good health? Are you good health? If yes, what condition is being treated?	
Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Are you now under the care of a physician? Physician Name: Phone: Include area code () Address/City/State/Zip: Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you in good health? Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: If yes, what condition is being treated?	
Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Are you now under the care of a physician? Phone: Include area code () Address/City/State/Zip: Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you in good health? If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: If yes, what condition is being treated?	
Are you now under the care of a physician? Phone: Include area code () Address/City/State/Zip: Are you in good health? Are you fact any condition is being treated? Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:	telepopular enteretronomo en un co
Are you now under the care of a physician? Phone: Include area code () Address/City/State/Zip: Are you in good health? Are you feel and content or or over the counter medicine(s)? Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: If yes, what condition is being treated?	
Are you now under the care of a physician? Phone: Include area code () Address/City/State/Zip: Are you in good health? Are you feel and content or or over the counter medicine(s)? Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: If yes, what condition is being treated?	
Physician Name: Phone: Include area code () If yes, what was the illness or problem? Address/City/State/Zip: Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you in good health? Has there been any change in your general health within the past year? If yes, what condition is being treated?	Yes No I
Physician Name: Phone: Include area code () If yes, what was the illness or problem? Address/City/State/Zip: Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you in good health? Has there been any change in your general health within the past year? If yes, what condition is being treated?	
Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you in good health? Has there been any change in your general health within the past year? If yes, what condition is being treated?	0 0 1
Are you taking or have you recently taken any prescription or over the counter medicine(s)? Are you in good health? Has there been any change in your general health within the past year? If yes, what condition is being treated?	
or over the counter medicine(s)? Are you in good health?	
or over the counter medicine(s)? Are you in good health?	
Has there been any change in your general health within the past year? and/or dietary supplements:	
Has there been any change in your general health within the past year? and/or dietary supplements:	
If yes, what condition is being treated?	
Data of last physical avam	
Date of last physical exam:	

© 2012 American Dental Association Form \$500

(Check DK if you Don't Know the answer to the question)	Yes No DK							No D
Do you wear contact lenses?		Do you use controlled subs	tances	(dru	igs)?			
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: If yes, have you had any complications?	000		ing, sno ou in sto	uff, o	hew,	, bidis)?		
Are you taking or scheduled to begin taking an antiresorptive agent							П	ПГ
(like Fosamax*, Actonel*, Atelvia, Boniva*, Reclast, Prolia) for		Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours?						
osteoporosis or Paget's disease?						a week?		
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia*, Zometa*, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?		WOMEN ONLY Are you: Pregnant? Number of weeks: Taking birth control pills or	hormo	nal r	– eplac	ement?	0	
Allergies. Are you allergic to or have you had a reaction to:							Yes	No D
To all yes responses, specify type of reaction.	Yes No DK							
Local anesthetics								
AspirinPenicillin or other antibiotics		lodine		-				
Barbiturates, sedatives, or sleeping pills								
Sulfa drugs								
Codeine or other narcotics								
							_ U	U L
Please mark (X) your response to indicate if you have or have not had	d any of the fo Yes No DK	llowing diseases or problem	s. Yes	No	DK		Yes	No D
Artificial (prosthetic) heart valve		Autoimmune disease				Glaucoma		
Previous infective endocarditis		Rheumatoid arthritis				Hepatitis, jaundice or		
Damaged valves in transplanted heart		Systemic lupus		_	_	liver disease		
Congenital heart disease (CHD)		erythematosus				Epilepsy		
Unrepaired, cyanotic CHD		Asthma				Fainting spells or seizures		
Repaired (completely) in last 6 months		Bronchitis	🗆			Neurological disorders		
Repaired CHD with residual defects		Emphysema				If yes, specify:		
		Sinus trouble				Sleep disorder		
Except for the conditions listed above, antibiotic prophylaxis is no longer rec for any ather form of CHD.	commended	Tuberculosis				Do you snore?		
Yes No DK	Yes No DK	Cancer/Chemotherapy/ Radiation Treatment	🗆			Mental health disorders Specify: Recurrent Infections		
Cardiovascular disease		Chest pain upon exertion				Type of infection:	. ப	
Angina Pacemaker		Chronic pain				Kidney problems		
Arteriosclerosis		Diabetes Type I or II	🗆			Night sweats		
Congestive heart failure		Eating disorder			-	Osteoporosis		
Damaged heart valves Abnormal bleeding		Malnutrition				Persistent swollen glands		
Heart attack Anemia		Gastrointestinal disease	🗆			in neck		
Heart murmur 🔲 🖂 🗆 Blood transfusion		G.E. Reflux/persistent				Severe headaches/ migraines		
Low blood pressure		heartburn				Severe or rapid weight loss		
High blood pressure		Ulcers				Sexually transmitted disease		
Other congenital AIDS or HIV infection		Thyroid problems Stroke				Excessive urination		
heart defects								
Has a physician or previous dentist recommended that you take antibiotics	prior to your de	ental treatment?	· commen	02106			🗆	
Name of physician or dentist making recommendation:						Phone: Include area code ()		
Do you have any disease, condition, or problem not listed above that you the Please explain:	nink I should kno	ow about?					🗆	
NOTE: Both doctor and patient are encouraged to discuss any and all certify that I have read and understand the above and that the information dentist and his/her staff will rely on this information for treating me. I acknow will not hold my dentist, or any other member of his/her staff, responsible completion of this form. Signature of Patient/Legal Guardian:	n given on this owledge that m	form is accurate. I understand by questions, if any, about inqu	the im	port	ance	bove have been answered to my omissions that I may have made	satisf	faction
Signature of Dentist:					Da			
orginature or Delitiot.					Da	ite.	- Contractor of the Contractor	
		TION BY DENTIST	and the same of the	in invite or or	NATIONAL PROPERTY.		and the best of the law has	Marketon Address