

Date: _____ Patient Name: _____

Are you under a physician's care now? Yes / No If Yes, Who? _____

Have you ever been hospitalized or had a major operation? Yes / No If yes, explain: _____

Have you ever had a serious head or neck injury? Yes / No If yes, explain: _____

Are you taking any medications, pills, or drugs? Yes / No If yes, please list them: _____

Do you take, or have you taken Phen-Fen or Redux? Yes / No If yes, when? _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes / No If yes, when? _____

Are you on a special diet? Yes / No Do you use tobacco? Yes / No

Women:

Are you pregnant or trying to get pregnant? Yes / No Nursing? Yes / No

Taking oral contraceptives? Yes / No

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic
Metal Latex Sulfa Drugs Local Anesthetics

Other: _____

Do you use controlled substances? Yes / No If yes, explain: _____

Do you have, or have you had any of the following?

- | | | |
|---------------------------|---------------------------|----------------------------|
| AIDS/HIV Positive | Excessive Bleeding | Lung Disease |
| Alzheimer's Disease | Excessive Thirst | Mitral Valve Prolapse |
| Anaphylaxis | Fainting Spells/Dizziness | Osteoporosis |
| Anemia | Frequent Cough | Pain in Jaw Joints |
| Angina | Frequent Diarrhea | Parathyroid Disease |
| Arthritis/Gout | Frequent Headaches | Psychiatric Care |
| Artificial Heart Valve | Genital Herpes | Anxiety/Panic Attack |
| Artificial Joint | Glaucoma | Radiation Treatments |
| Asthma | Hay Fever | Recent Weight Loss |
| Blood Disease | Heart Attack/Failure | Renal Dialysis |
| Blood Transfusion | Heart Murmur | Rheumatic Fever |
| Breathing Problems | Heart Pacemaker | Rheumatism |
| Bruise Easily | Heart Trouble/Disease | Scarlet Fever |
| Cancer | Lyme Disease | Shingles |
| Chemotherapy | Hemophilia | Sickle Cell Disease |
| Chest Pains | Hepatitis A | Sinus Trouble |
| Cold Sores/Fever Blisters | Hepatitis B or C | Spina Bifida |
| Congenital Heart Disorder | Herpes | Stomach/Intestinal Disease |
| Convulsions/Seizures | High Blood Pressure | Stroke |
| Jaundice | High Cholesterol | Swelling of Limbs |
| Depression | Hives or Rash | Thyroid Disease |
| Cortisone Medicine | Hypoglycemia | Tonsillitis |
| Diabetes | Irregular Heartbeat | Tuberculosis |
| Drug Addiction | Kidney Problems | Tumors or Growths |
| Easily Winded | Leukemia | Ulcers |
| Emphysema | Liver Disease | Venereal Disease |
| Epilepsy or Seizures | Low Blood Pressure | Dry Mouth |

Have you ever had any serious illness not listed above? Yes / No If yes, explain: _____