



Name _____ Birthday _____

Have you had any serious illnesses operations?, If yes, describe: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? _____

Women: Are you pregnant? Nursing?

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU MAY CURRENTLY HAVE:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hives/Rash | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Congenial Heart Disorder | <input type="checkbox"/> Heart Pacemaker | | |

Serious illness not listed above? If so, what? _____

MEDICATIONS

List medications you are currently taking:

ALLERGIES

- | | |
|--|--------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Codeine | _____ |
| <input type="checkbox"/> Local Anesthetic | _____ |
| <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> Sulfa | _____ |

The above information is accurate and complete to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature _____ Date _____