Chest Pain Yes No Diabetes Yes No Venereal Disease Yes Congenital Heart Disease Yes No Thyroid Problems Yes No A.I.D.S./H.I.V. Positive Yes Heart Murmur Yes No Glaucoma Yes No Cold Sores/Fever Blisters Yes High/Low Blood Pressure Yes No Contact lenses Yes No Blood Transfusion Yes Mitral Valve Prolapse Yes No Emphysema Yes No Hemophilia Yes Artificial Heart Valve/Pacemaker Yes No Chronic Cough Yes No Sickle Cell Disease Yes Rheumatic Fever Yes No Tuberculosis Yes No Bruise Easily Yes Arthritis/Rheumatism Yes No Asthma Yes No Asthma Yes No Liver Disease/Yellow Jaundice Yes Cortisone Medicine Yes No Latex Sensitivity Yes No Neurological Disorders Yes Swollen Ankles Yes No Latex Sensitivity Yes No Fainting or Dizzy Spells Yes Diet (Special/Restricted) Yes No Radiation Therapy Yes No Psychiatric/Psychological Care. Yes Artificial Joints (hip, knee, etc.) Yes No Chemotherapy Yes No Psychiatric/Psychological Care. Yes If yes, please list: 10. Women: Are you pregnant or think you could be pregnant? Yes Months No Nursing? Yes No Independent Medical Care in a safe and efficient manner. I	nt Account No.			Medical Alert			MEDICAL F		
Have you had any medical care within the past two years? Describe Any surgeries? When? 2. Have you taken any medication or drugs during the past two years? If yes, please list name and dosage 3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? Yes If yes, please list name and dosage 4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? Yes If yes, please list name and dosage 5. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes If yes, please specify 6. Have you been a patient in the hospital during the past five years? 7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item. Heart (Surgery, Disease, Attack). Yes No Diabetes Yes No Diabetes Yes No Congenital Heart Disease Yes No Congenital Heart Disease Yes No Glaucoma Yes No Glaucoma Yes No Glod Sores/Fever Blisters Yes No HempflyLow Blood Pressure Yes No Contact lenses Yes No HempflyLow Blood Transfusion Yes No HempflyLow Blood Pressure Yes No Tuberculosis Yes No HempflyLow Blood Transfusion Yes No HempflyLow Blood Transfusion Yes No HempflyLow Blood Pressure Yes No Tuberculosis Yes No HempflyLow Blood Transfusion Yes No HempflyLow He	1 – Physician's Namo			Pho	ne (,			
Describe Any surgeries? when? 2. Have you taken any medication or drugs during the past two years? Yes If yes, please list name and dosage 3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? Yes If yes, please list name and dosage 4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? Yes If yes, please list name and dosage 5. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes If yes, please specify 6. Have you been a patient in the hospital during the past five years? Yes If yes, please, please, Attack). Yes No Ulcers 7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item. Heart (Surgery, Disease, Attack). Yes No Ulcers Yes No Hepatitis A B C (circle). Yes Chest Pain Yes No Venereal Disease Yes No Venereal Disease Yes No ALD.S./H.I.V. Positive Yes No Congenital Heart Disease Yes No Glaucoma Yes No Gold Sores/Fever Blisters Yes No Blood Pressure Yes No Contact lenses Yes No Blood Transfusion. Yes No Hiphysema Yes No Blood Transfusion Yes No Bruise Easily Yes No Hayberunatism Yes No Chronic Cough Yes No Bruise Easily Yes No Hayberunatism Yes No Latex Sensitivity Yes No Epilepsy or Scizures Yes No Psychiatric/Psychological Disorders Yes No Latex Sensitivity Yes No Epilepsy or Scizures Yes No Psychiatric/Psychological Care. Yes No Chemotherapy Yes No Psychiatric/Psychological Care. Yes No Chemotherapy Yes No Psychiatric/Psychological Care. Yes No Latex Sensitivity Yes No Psychiatric/Psychological Care. Yes No Linders No Women: Are you pregnant or think you could be pregnant? Yes No Dyou have or have you had any disease, condition, or problem not listed? Yes No Carcer Yes No Lunderstand the above information is necessary to provide me with dental care in a safe and efficient manner. I									No
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If yes, please list name and dosage	2. Have vou taken any medication o	r druas durina	the past two vears	?				Yes	No
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If yes, please list name and dosage 4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? 5. Are you aware of having an allergic (or adverse) reaction to any substance or medication? 15. Are you aware of having an allergic (or adverse) reaction to any substance or medication? 16. Have you been a patient in the hospital during the past five years? 17. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item. 18. Heart (Surgery, Disease, Attack). 18. Yes No Ulcers Yes No Hepatitis A B C (circle) Yes Congenital Heart Disease Yes No Diabetes Yes No Venereal Disease Yes No Congenital Heart Disease Yes No Thyroid Problems Yes No Cold Sores/Fever Bilsters Yes Heart Murmur Yes No Glaucoma Yes No Cold Gores/Fever Bilsters Yes High/Low Blood Pressure Yes No Contact lenses Yes No Blood Transfusion Yes Artificial Heart Valve/Pacemaker Yes No Emphysema Yes No Blood Transfusion Yes Artificial Heart Valve/Pacemaker Yes No Chronic Cough Yes No Sickle Cell Disease Yes No Rheumatic Fever Yes No Tuberculosis Yes No Bruise Easily Yes Arthritis/Rheumatism Yes No Asthma Yes No Liver Disease/Yellow Jaundice Yes No Hay Fever/Allergy/Hives Yes No Neurological Disorders Yes Stroke Yes No Bruise Tasily Yes No Englepsy or Seizures Yes Stroke Yes No Radiation Therapy Yes No Nervous/Anxious Yes Stroke Yes No Radiation Therapy Yes No Nervous/Anxious Yes Artificial Joints (filp, knee, etc.) Yes No Chemotherapy Yes No Psychiatric/Psychological Care. Yes If yes, please list: 18. Have you lost or gained more than 10 pounds in the past year? 19. Do you have or have you had any disease, condition, or problem not listed? 19. Womer: Are you pregnant or think you could be pregnant? Yes Months No Nursing? Yes No Inuderstand the above information is necessary to provide me with dental care in a safe and efficient manner. I		•						Yes	No
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answered all questions to the best of my knowledge. Should further information be needed, you have my permis ask the respective health care provider or agency, who may release such information to you. I will notify the doc any change in my health or medication.	9. Do you have or have you had any If yes, please list:	nink you couk ions?mation is n e best of m	dition, or problem not be pregnant? You be cessary to prove knowledge. Slor agency, who	et listed?Mo lesMo les with a could further	onths denta	No Il care in	Nursing? Yes No n a safe and efficient manr be needed, you have my p	Yes Yes ner. I ha	į
Patient/Guardian Signature Date	Patient/Guardian Signature						Date		