

## Medical Information

1. Are you having pain or discomfort at this time? .....
2. Have you been a patient in the hospital during the last two years? .....
3. Are you now taking any medication or drugs? .....

If yes, please list: \_\_\_\_\_

4. Have you ever taken Fosamax or any other bisphosphonate?.....
5. Have you been under the care of a medical doctor during the last two years or since taking any of the appetite suppressants named above? .....

Physicians name \_\_\_\_\_ Ph. # (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

6. Are you sensitive to any medication or anesthetics? .....

If yes, please list: \_\_\_\_\_

7. Indicate which of the following you have had or have at the present. Select Yes or No using the drop down menu.

Heart failure.....	Artificial Joints (hip, knee, etc.)	Hepatitis A (infectious).....
Heart Disease or Attack.....	Kidney Trouble.....	Hepatitis B (serum).....
Angina Pectoris.....	Ulcers.....	Venereal Disease.....
Congenital Heart Disease.....	Diabetes.....	A.I.D.S.....
Heart Murmur.....	Thyroid Problems.....	H.I.V. Positive.....
High Blood Pressure.....	Glaucoma.....	Cold Sores/ Fever Blisters..
Arteriosclerosis.....	Cancer.....	Blood Transfusion.....
Mitral Valve Prolapse.....	Emphysema.....	Hemophilia.....
Artificial Heart Valve.....	Chronic Cough.....	Anemia.....
Heart Pacemaker.....	Tuberculosis.....	Sickle Cell Disease.....
Heart Surgery.....	Asthma.....	Bruise Easily.....
Rheumatic Fever.....	Hay Fever.....	Liver Disease.....
Arthritis.....	Allergies or Hives.....	Yellow Jaundice.....
Rheumatism.....	Sinus Trouble.....	Epilepsy or Seizures.....
Cortisone Medicine.....	Radiation Therapy.....	Fainting or Dizzy Spells....
Drug Addiction.....	Chemotherapy.....	Nervousness.....
Stroke.....	Developmentally Disabled.....	Tumors.....
Allergy to Latex.....	Allergy to metal (jewelry, etc.)...	

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?.....
- 9.Do your ankles swell during the day? .....
- 10.Do you use more than two pills to sleep? .....
- 11.Have you lost or gained more than ten pounds in the past year? .....
- 12.Do you ever wake up from sleep and feel short of breath? .....
- 13.Are you on a special diet? .....
- 14.Do you have or have you had any disease, condition, or problem not listed?.....

If yes, please list: \_\_\_\_\_

<b><u>FOR WOMEN ONLY</u></b>			
Are you pregnant?	What month?	Are you nursing?	Are you taking birth control pills?
I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.			
Emergency Contact _____		Phone (____) _____	
Patient Signature _____		Date _____	
<b>For Office Use: Reviewed by Dr.</b> _____ <b>Date</b> _____			