

Physician_____

Your Insurance I.D.#_____

Address _____ Phone(s) _____

Your Age_____ Height_____ Weight_____ Mo/Year of Your Last Medical Examination_____

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH (CIRCLE ONE): EXCELLENT GOOD FAIR POOR DON'T KNOW

YES NO ???

- Has there been any change in your general health in the past year?
- Have you had a serious illness, operation or hospitalization during the past five years?
If yes, please describe_____
- Are you taking or have you recently taken any of the following:
Prescribed medications & inhalers:_____
- Over the counter, natural or herbal preparations:_____
- You've taken: Aredia, Zometa, Fosamax or any other Biphosphonates thru I.V., or orally?
- Has your M.D. told you to take antibiotics prior to having any type of dental procedure?
- Are you allergic to any Medications or Drugs, Latex, Iodine?
- Have you ever had adverse reaction to any drugs, anesthetics, sedatives, narcotics, aspirin, ibuprofen (Motrin)?
- Have you ever had excessive bleeding that required special treatment?
- Have you been diagnosed as having any Immunodeficiency, Systemic Lupus, ARC or AIDS?
- Is there a history of diabetes in your family?
- Are you required, due to health, to restrict your work or activity in any way?
- Are you on a special or restricted diet of any kind? _____
- Do you use any kind of tobacco? If so, how much: _____ per day, week, month
- Do you use any kind of alcohol? If so, how much: _____ per day, week, month
- Do you have any history of substance abuse or do you currently use recreational drugs?

FOR WOMEN, CHECK ALL THAT ARE APPROPRIATE: I am pregnant I am nursing I am taking birth control pills

CHECK ALL OF THE FOLLOWING THAT YOU MAY HAVE HAD IN THE PAST OR THAT CURRENTLY APPLY TO YOU:

- | | | | |
|---|---|---|------------------------------------|
| <input type="checkbox"/> Chest pain upon exertion | <input type="checkbox"/> Received blood transfusion | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Impaired liver function | <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Bronchitis | Epilepsy |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Impaired kidney function | <input type="checkbox"/> Emphysema | Seizures |
| <input type="checkbox"/> Heart valve prolapse | <input type="checkbox"/> Esophygeal reflux | <input type="checkbox"/> Sinus trouble | Mental health problems |
| <input type="checkbox"/> Congenital heart lesion | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Persistent cough | |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> G.I ulcers | <input type="checkbox"/> Tuberculosis | Glaucoma |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Anorexia or bulimia | | Wear contacts |
| <input type="checkbox"/> Damaged heart valve | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Joint replacement surgery | Severely impaired vision |
| <input type="checkbox"/> Heart arrhythmia | <input type="checkbox"/> Colitis | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Connective tissue disorder | Recurrent infections |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Osteoporosis | Chronic fatigue |
| <input type="checkbox"/> Cadiac pacemaker | <input type="checkbox"/> Chemotherapy | | Recent weight loss |
| <input type="checkbox"/> Hepatitis or jaundice | <input type="checkbox"/> History of cancer | <input type="checkbox"/> Neurological disorders | |
| | | <input type="checkbox"/> Stroke | |

Do you have any disease, problem or condition not listed above? Please explain:_____

Signature of patient or legal guardian

Date

Reviewed by