

- n. Kidney trouble YES NO
- o. Tuberculosis YES NO
- p. Do you have thyroid disease YES NO
- q. Low blood pressure YES NO
- r. Venereal disease YES NO
- s. Emotional or psychiatric problems, describe them YES NO
- t. Glaucoma YES NO
- u. Chronic viral or bacterial infections, what type? YES NO
7. Have you had abnormal bleeding associated with previous medical or dental treatment, surgery, or trauma YES NO
- a. Do you bruise easily YES NO
- b. Have you ever had a blood transfusion YES NO
- If so, explain the circumstances _____
8. Do you have any blood disorder such as anemia YES NO
9. Have you had surgery or radiation treatment for a tumor or other condition of your mouth, head or neck YES NO
10. Are you taking any of the following? (Please write drug name on appropriate line)
- a. Antibiotics or sulfa drugs YES NO
- b. Anticoagulants (blood thinners) YES NO
- c. Medicine for high blood pressure YES NO
- d. Cortisone (steroids) YES NO
- e. Tranquilizers YES NO
- f. Antihistamine YES NO
- g. Aspirin YES NO
- h. Insulin, tolbutamide (Orinase) or similar drug YES NO
- i. Digitalis or drugs for heart trouble YES NO
- j. Nitroglycerin YES NO
11. Please list any drugs you are currently taking _____
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12. Are you currently taking any vitamins or herbal supplements? If yes, please list _____
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13. Have you ever taken or are you currently taking prescription diet medications such as Phen-Fen or Redux YES NO
14. Are you allergic to or have you reacted adversely to:
- a. Local anesthetics YES NO
- b. Penicillin YES NO
- c. Sulfa drugs YES NO
- d. Barbituates, sedatives, or sleeping pills YES NO
- e. Aspirin YES NO
- f. Iodine YES NO
- g. Codeine or other narcotics YES NO
- h. Latex YES NO
- i. Other (including food allergies) _____
15. Have you had any serious trouble associated with any previous medical or dental treatment YES NO
- If so, explain _____
16. Have you ever been told of a need to be premedicated with antibiotics prior to dental care? YES NO
17. Do you have any disease, condition, or problem not listed above that you think I should know about YES NO
- If so, explain _____
18. Do you wear contact lenses YES NO
19. Have you had or been treated for Myeloma, Cancer, Paget's Disease or Osteoporosis YES NO
- If so, explain _____
20. Have you had oral or IV bisphosphonate therapy? (Circle YES if you have taken Fosamax, Actonel, Aredia, Zometa, Didronel, or Bonica.. YES NO
- If so, explain _____
- WOMEN
19. Are you pregnant YES NO
20. Are you breast feeding an infant YES NO
21. Do you have any problems associated with your period YES NO
- MEN
22. Prostate gland problems YES NO

ADDITIONAL REMARKS:

SIGNATURE OF PATIENT OR GUARDIAN