# Medical History

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| **Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?<br>Date: _____<br>If yes, have you had any complications?<br>_____ | Yes | No | Since 2001, were you treated or are you presently scheduled to being treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?<br>Date Treatment Began: _____ | Yes | No |
| Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? | Yes | No | Do you use tobacco (smoking, snuff, chew, bidis)? | Yes | No |
| Do you use controlled substances (drugs)? | Yes | No | Do you drink alcoholic beverages? | Yes | No |

**Women Only** Are you: (Circle any of the following)

Pregnant/ Trying to get pregnant? Nursing? Taking oral contraceptives?

**Allergies** – Are you allergic to or have you had a reaction to: (Circle any of the following)

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| Local Anesthetics | Iodine | Penicillin | Barbiturates, sedatives, or sleeping pills | Latex (rubber) |
| Sulfa drugs | Codeine or Other Narcotics | Metals | Other _____ | |

Do you have, or have had any of the following **diseases** or **problems**?

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| AIDS/HIV Positive | Yes | No | Cortisone Medicine | Yes | No | Hemophilia | Yes | No | Radiation Treatments | Yes | No |
| Alzheimer's Disease | Yes | No | Diabetes | Yes | No | Angina | Yes | No | Recent Weight Loss | Yes | No |
| Anaphylaxis | Yes | No | Drug Addiction | Yes | No | Hepatitis B or C | Yes | No | Anemia | Yes | No |
| Emphysema | Yes | No | Herpes | Yes | No | Rheumatic Fever | Yes | No | Night Sweats | Yes | No |
| Epilepsy or Seizures | Yes | No | High/Low Blood Pressure | Yes | No | Rheumatism | Yes | No | Arthritis/Gout | Yes | No |
| Excessive Bleeding | Yes | No | High Cholesterol | Yes | No | Scarlet Fever | Yes | No | Artificial Heart Valve | Yes | No |
| Psychiatric Care | Yes | No | Persistent Swollen Glands in Neck | Yes | No | Shingles | Yes | No | Artificial Joint | Yes | No |
| Irregular Heartbeat | Yes | No | Hypoglycemia | Yes | No | Asthma | Yes | No | Fainting Spells/ Dizziness | Yes | No |
| Blood Transfusion | Yes | No | Sinus Trouble | Yes | No | Blood Disease | Yes | No | Kidney Problems | Yes | No |
| Frequent Headaches | Yes | No | Leukemia | Yes | No | Stroke | Yes | No | Breathing Problems | Yes | No |
| Sexually Transmitted Diseases | Yes | No | Liver Disease | Yes | No | Swelling of Limbs | Yes | No | Bruise Easily | Yes | No |
| Glaucoma | Yes | No | Excessive Urinations | Yes | No | Thyroid Disease | Yes | No | Cancer | Yes | No |
| Osteoporosis | Yes | No | Lung Disease | Yes | No | Chest Pain | Yes | No | Chemotherapy | Yes | No |

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| Pain in Jaw Joint | Yes | No | Tonsillitis | Yes | No | Cold Sores/Fever Blisters | Yes | No | Heart Attack/Failure | Yes | No |
| Parathyroid Disease | Yes | No | Tuberculosis | Yes | No | Congestive Heart Failure | Yes | No | Heart Murmur | Yes | No |
| Recurrent Infections | Yes | No | Tumors or Growths | Yes | No | Convulsions | Yes | No | Heart Pacemaker | Yes | No |
| Malnutrition | Yes | No | Ulcers | Yes | No | Arteriosclerosis | Yes | No | Heart Trouble/Disease | Yes | No |
| Damaged Heart Valves | Yes | No | Mitral Valve Prolapse | Yes | No | Autoimmune Disease | Yes | No | G.E. Reflux / persistent heartburn | Yes | No |
| Systemic Lupus Erythematosus | Yes | No | Chronic Pain | Yes | No | Eating Disorder | Yes | No | Gastrointestinal Disease | Yes | No |

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|---|---|
| Are you interested in braces/invisalign? | |
| Are you presently in any dental pain? | |
| Have you had your wisdom teeth removed? | |
| Have you ever experienced any unfavorable reaction to dentistry? | |
| Have you ever experienced chronic ringing in the ear? | |
| Do you get tension headaches? | |

**Please List All Medication Below:**

Patient Name: _____ Date of Birth: _____

Signature: _____