

Patient Personal/Medical/Dental History

Name _____ Soc. Sec. # _____ - _____ - _____ Age _____

Circle any of the following which you have had or have at present:

- | | | | | |
|------------------------|----------------------|--------------------------|--------------------------|-----------------------------------|
| Heart Condition | Anemia or Hemophilia | Skin Rashes or Hives | Thyroid Disease | Radiation therapy (X-Ray, Cobalt) |
| Heart Attack or Stroke | Bruise Easily | Kidney Trouble | Cortisone Medicine | Chemotherapy (Cancer, Leukemia) |
| Heart Murmur | Shortness of Breath | Diabetes | Glaucoma | HIV Positive/AIDS |
| Chest pains (Angina) | Swelling of Ankles | Sickle Cell Disease | Arthritis or Rheumatism | Venereal Disease |
| Heart Surgery | Artificial Joint | Liver Disease | Pain in Jaw Joints | Genital Herpes |
| Artificial Heart Valve | Lung Disease | Hepatitis A (infectious) | Fainting or Dizzy Spells | Cold Sores |
| Heart Pacemaker | Emphysema | Hepatitis B (serum) | Alcoholism | Epilepsy or Seizures |
| High Blood Pressure | Tuberculosis (T.B.) | Yellow Jaundice | Drug Addiction | Psychiatric Treatment |
| Rheumatic Fever | Asthma or Hay Fever | Blood Transfusion | Cancer or Tumor | Osteoporosis |
| Mitral Valve Prolapse | | | | |

Have you ever had any other serious illness not circled above? _____ YES NO

Please describe in detail _____

Please answer each question. Check yes or no. If in doubt, leave blank.

- * YES NO
1. Are you in good health now?
2. Are you now under the care of a physician?
- If so, what is the condition being treated? _____
3. Do you use tobacco in any form? If yes, how much _____
4. Are you ALLERGIC or have you ever experienced any reaction to the following?

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Local anesthetics (e.g. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> | Latex | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates/sedatives/sleeping pills | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin or codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin/other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> |

Other allergies _____

5. Are you taking any of the following?
- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Antibiotics/sulfa drug | <input type="checkbox"/> | <input type="checkbox"/> | Tranquilizers | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood thinners | <input type="checkbox"/> | <input type="checkbox"/> | Insulin/other diabetes drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure medication | <input type="checkbox"/> | <input type="checkbox"/> | Recreational drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid medicine | <input type="checkbox"/> | <input type="checkbox"/> | Digitalis/other heart medications | <input type="checkbox"/> | <input type="checkbox"/> |
| Cortisone/steroids | <input type="checkbox"/> | <input type="checkbox"/> | Nitroglycerin | <input type="checkbox"/> | <input type="checkbox"/> |
| Antihistamines/allergy drugs/cold remedies | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |

Other medication _____

If yes to any of the above, list **name** of medication and **dosage** below:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

* Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? YES NO

	YES	NO		YES	NO
Women: Are you pregnant now? Due date _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you anticipate becoming pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you practicing birth control?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any complications or problems with a previous pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>

6. Physician's _____ Phone _____

