Please download before you start to complete all the form fields.

Patient Name	Today's Date
Best Phone	Date of Birth

Please answer each of the medical history questions below

yes	no	
		Do you have an **artificial heart valve?** If yes, What year was it placed?___________
		Do you have an **artificial joint?** (total hip, knee, etc. Answer 'no' if only pins/plates) If yes, What year was it placed?___________
		Were you born with a **heart defect?**
		Do you have trouble with excessive or prolonged **bleeding?** i.e, after minor cuts etc.?
		Have you taken corticosteriods orally for 14+ days within the past 2 years? **(CORTISONE, PREDNISONE, PREDNISOLONE, FLUDROCORTISONE, ETC)**
		Have you ever taken **oral bisphosphonate** drugs, commonly used to treat osteoporosis? **(ACTONEL, BONIVA, FOSAMAX, SKELID, DIDRONEL, ETC)**
		Women, could you be/are you **pregnant?**

yes	no	
		Do you have any known **drug allergies?**
		Have you ever received head, neck, or jaw **radiation treatments?**
		Do you take any **medications** regularly?
		Has a doctor advised you to take **prophylactic antibiotics** prior to dental appointments?
		Do you have a **pacemaker?**
		Have you ever had **infective endocarditis?** (Inflammation of the heart valves)
		Are you currently taking strong blood anti-coagulants (thinners) such as **COUMADIN, WARFARIN, JANTOVEN, MAREVAN, LAWARIN, WARAN, WARFANT, ETC?**
		Have you ever been administered **I.V. bisphosphonate** drugs, commonly used to treat cancer? **(AREDIA, ZOMETA, BONEFOS, ETC)**
		Women, are you **breast feeding?**

For the conditions listed below, please check yes or no if you currently have, or have had in the past.

yes	no	
		Artificial Heart
		Heart Transplant
		Artificial Heart Valve
		Artificial Joints
		Asthma, Severe
		Chemotherapy
		Coumadin/Warfarin, Other Strong Anticoagulants
		Easily Winded
		Bleeds Excessively When Cut
		Previous Heart Attack
		High Blood Pressure
		Jaundice

yes	no	
		Bisphosphonate Use
		Chest Pains
		Diabetes
		Emphysema
		Glaucoma, Narrow Angle
		Heart Disease/Trouble
		HIV/AIDS
		Kidney Disease
		Local Anesthetic Allergy
		Pacemaker
		Stroke
		Currently Pregnant/Nursing

yes	no	
		Epilepsy
		Swollen Ankles
		Hepatitis
		Immunosuppression
		Latex Allergy
		Addison's Disease
		Head, Neck, or Jaw Radiation Treatment
		Angina
		Bone Cancer
		Liver Disease
		Infective Endocarditis History
		Dialysis Treatments

PLEASE INITIAL HERE_______________________

AND CONTINUE WITH OPPOSITE SIDE OF PAGE

Please list any medications, drugs, and/or herbal remedies you take below, **or write "none"** if applicable. Attach additional pages if needed:

Please list any known drug allergies below, **or write "none"** if applicable.

Please describe anything else about your medical history that could be important, i.e. types of congenital heart defects, conditions not listed on front page, hospitalizations, surgical operations, etc. Attach additional pages if needed.

Please fill in the important names and numbers listed below:

	Name	Telephone Number
General Physician		( ) -
Bone/joint Doctor		( ) -
Heart Doctor		( ) -
Emergency Contact		( ) -

I certify that I have read and understand all of the questions on the front and back of this page, and that I have answered these questions to the best of my knowledge. I understand that providing false and/or incomplete information could place my health in danger when receiving dental treatment.

Signature ______________________________ ____________________

Patient, Parent, or Guardian who filled out form Today's date

Printed ______________________________

Patient, Parent, or Guardian who filled out form