HEALTH QUESTIONNAIRE

Are you having dental pain or discomfort now?	Yes	No
Have there been changes in your general health in the last two years?	Yes	No
Have you been a patient in a hospital in the last two years?	Yes	No
Have you ever been informed of the need for premedication prior to dental treatment?	Yes	No
Have you been under a medical doctor's care in the last two years?	Yes	No
Are you currently taking or have you previously taken any bisphosphinate medications such as Actonel ®, Fosamax ® or Zometa ® within the past 12 years?	Yes	No

Physician's Name: _____

CHECK ANY OF THE FOLLOWING PROBLEMS THAT YOU HAVE HAD OR HAVE NOW

CARDIO VASCULAR SYSTEM
__ High Blood Pressure
__ Low Blood Pressure
__ Heart Attack
__ Heart Surgery
__ Rheumatic Heart or Fever
__ Stroke
__ Other_____

NERVOUS SYSTEM
__ Epilepsy
__ Nervous Breakdown
__ Drug Dependency
__ Other_____

RESPIRATORY SYSTEM
__ Tuberculosis
__ Pneumonia
__ Asthma
__ Sinus Trouble
__ Do you smoke? Yes No
__ Other_____

GENITOURINARY SYSTEM
__ Kidney Disease
__ Other_____

HEAD
__ Head or Jaw Injuries
__ Headaches
__ Dizziness
__ Other_____

GASTROINTESTINAL SYSTEM
__ Stomach Trouble
__ Liver Disease
__ Hepatitis
__ Ulcers
__ Other _____

ENDOCRINE SYSTEM
__ Diabetes
__ Thyroid Disease
__ Other _____

SKELETAL SYSTEM
__ Arthritis
__ Neck Injuries
__ Joint Replacements
__ Other _____

BLOOD SYSTEM
__ Anemia
__ Abnormal Bleeding
__ Transfusions
__ Other _____

INFECTIOUS DISEASES
__ Hepatitis
__ Venereal Disease
__ HIV pos.π
__ AIDS
__ Herpes
__ Other _____

MEDICATIONS (Current or in the immediate past)

__ Antibiotics
__ Blood Pressure Medications
__ Antihistamines
__ Anticoagulants
__ Tranquilizers
__ Chemotherapy
__ Cortisone
__ Aspirin
__ Alcohol
__ Other_____

ALLERGIES
__ Local Anesthetics
__ Aspirin
__ Penicillin
__ Codeine
__ Sulfa Drugs
__ Other_____

WOMEN ONLY: Are you pregnant? Yes No Maybe Taking Oral Contraceptives? Yes No

Please describe any disease or problems not listed above: _____

To my knowledge, the answers above are correct. Pulse_____ Blood Pressure _____

Signature: X _____ Date: _____

Witness:_____ Date: _____