

PATIENT INFORMATION

CONFIDENTIAL

PLEASE CHECK OFF ANY ALLERGIES YOU MAY HAVE TO THE FOLLOWING:

- Local anesthetics Latex Penicillin Sulfa
- Codeine Aspirin Ibuprofen Other: _____

1. Have you been told by your MEDICAL doctor you are required to pre-medicate prior to dental treatment due to prosthetic implants or heart problems? If yes, for what condition? _____

2. If you are you currently taking blood thinners indicate FOR WHAT CONDITION? _____
Name of blood thinner you are currently taking: _____
NAME OF PRESCRIBING DOCTOR: _____ Town: _____ State: _____

3. PLEASE PRINT CLEARLY AND LIST ALL MEDICATIONS including vitamins and supplements.

Medication: _____ reason for taking: _____
Medication: _____ reason for taking: _____
Medication _____ reason for taking _____
Medication _____ reason for taking _____
Medication _____ reason for taking _____
Medication _____ reason for taking _____
Medication _____ reason for taking _____

4. CHECK ALL WHICH APPLY IN THE PAST 10 YEARS.

- | | | |
|-------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Damaged heart valve | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Back problems |
| <input type="checkbox"/> Mitral valve prolapsed | <input type="checkbox"/> Hepatitis –Type: _____ | <input type="checkbox"/> Cortisone treatments- Location: _____ |
| <input type="checkbox"/> Prosthetic heart valve | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> Smoke / chew tobacco (currently) |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pregnant (currently) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Persistent / bloody cough | <input type="checkbox"/> nursing (currently) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Diabetes? Type 1 / Type 2 _____ | |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Epilepsy / seizure disorder _____ | |
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Cancer – Type: _____ | |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Chemotherapy / Radiation | |

5. Within the last 10 years, have you ever taken any bisphosphonate drugs? These include: (PLEASE CIRCLE)
Alendronate (Fosamax) , Risedronate (Actonel), Etidronate (Didronel), Ibandronate (Boniva), Pamidronate (Aredia), Zoledronate (Zometa)

6. Have you ever taken any of the group of drugs referred to as “fen-phen”, these include combinations of Lonimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)? YES / NO

**I attest the information provided above is true and accurate. I accept full responsibility for any information not shared with the doctor.

Patient Name (PRINT) _____

Date: _____ Patient or Parent/Guardian Signature (SIGN) _____