

Angina Yes No Emphysema Yes No High Blood Pressure Yes No Rheumatism Yes No Arthitis/Gout Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Scarlet Fever Yes No Artificial/Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Shingles Yes No Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Asthma Yes No Fainting Spells/Dizziness Yes No Irregular Heartbeat Yes No Sinus Trouble Yes No Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Stomach/Intestinal Disease Yes No Breathing Problem Yes No Frequent Headaches Yes No Low Blood Pressure Yes No Stomach/Intestinal Disease Yes No Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes No Chest Pains Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tumors or Growths Yes No Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths	PATIENT NA	ME:				Birth Date:			
Have you ever been hospitalized or had a major operation?	have, or medication that								
Have you ever been hospitalized or had a major operation?	Δre	vou under a ni	ovsician's care now?	Ves	$\bigcirc$ No	If yes inlease evinlair	·		
Have you ever had a serious head or neck injury?									
Are you taking any medications, pills or drugs?   Yes   No   Do you take, or have you taken, Fen-Phen or Redux?   Yes   No   Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?   Yes   No   Do you use tobacco?   Yes   No   Do you use controlled substances?   Yes   No   Do you use controlled substances?   Yes   No   Pregnant/Trying to get pregnant?   Yes   No   Taking oral contraceptives?   Yes   No   Nursing?   Yes   No   Are you allergic to any of the following?   Alpsi-fill Yesitive   Yes   No   Alzbeimers Disease   Yes   No   Anaphylaxis   Yes   No   Anaphylaxis   Yes   No   Anagina   Yes   No   Anagina   Yes   No   Arthitic/Gout   Yes   N					_				
Do you take, or have you taken, Fen-Phen or Redux? Yes No Have you ever taken Fosamax, Boniva, Actorel or any other medications containing bisphosphonates? Yes No Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No Nomen: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Nu									
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No No Nursing? Yes No Do you use controlled substances? Yes No No Nursing? Yes No Norsing? Yes No Nursing? Yes No Nursing? Yes No Norsing? Yes No Nursing? Yes No Norsing? Yes Norsing	, , , , , , , , , , , , , , , , , , , ,				_	ii yes, piease expiaii	I		
other medications containing bisphosphonates?   Yes   No   Are you on a special diet?   Yes   No   Do you use tobacco?   Yes   No   Do you use tobacco?   Yes   No   Do you use controlled substances?   Yes   No   Pregnant/Trying to get pregnant?   Yes   No   Taking oral contraceptives?   Yes   No   Nursing?   Yes   No   Are you allergic to any of the following?   Alshim   Penicillin   Codeine   Local Anesthetics   Acrylic   Metal   Latex   Sulfa Drugs    Do you have, or have you had, any of the following?   AlDS/HIV Positive   Yes   No   Alzheimers Disease   Yes   No   Alzheimers Disease   Yes   No   Anaphylaxis   Yes   No   Anaphylaxis   Yes   No   Anaphylaxis   Yes   No   Angina   Yes   No   Easily Winded   Yes   No   Arthitics/Out   Yes   No   Earliepsy or Seizures   Yes   No   Arthitics/Out   Yes   No   Excessive Dieeding   Yes   No   Arthitical Joint   Yes   No   Blood Diransfusion   Yes   No   Breathing Problem   Yes   No   Br	•	•	_	) 165	ONO				
Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No No Do you use controlled substances? Yes No No Nursing? Yes No Nomen: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No					○No				
Do you use tobacco? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Nursing? Yes No  Array you allergic to any of the following?					_				
Do you use controlled substances?   Yes   No		•	•		_				
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No  Are you allergic to any of the following?  Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs  Other If other, please explain:  Po you have, or have you had, any of the following?  AlDS/HIV Positive Yes No Diabetes Yes No Alzheimers Disease Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No Anaphylaxis Yes No Drug Addiction Yes No Hepatitis Bor C Yes No Renal Dialysis Yes No Angina Yes No Emphysema Yes No High Blood Pressure Yes No Rheumatic Fever Yes No Arthitics/Gout Yes No Excessive Bleeding Yes No High Cholesterol Yes No High Cholesterol Yes No Scarlet Fever Yes No Asthma Yes No Frequent Cough Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Blood Disease Yes No Frequent Cough Yes No Luker Diarrhea Yes No Bruste Easily Yes No Frequent Headaches Yes No Luker Diarrhea Yes No Congenital Heart Disorder Yes No Heart Murmur Yes No Congenital Heart Disorder Yes No Heart Murmur Yes No Congenital Heart Disorder Yes No Heart Murmur Yes No Congenital Heart Disorder Yes No Heart Murmur Yes No Congenital Heart Disorder Yes No Heart Murmur Yes No Congenital Heart Disorder Yes No Heart Murmur Yes No Congenital Heart Disorder Yes No Heart Murmur Yes No Paychidic Care Yes No Vonereal Disease Yes No Convulsions Yes No Heart Trouble/Disease Yes No Paychidit Care Yes No Vonereal Disease Yes No Vonereal Disease Yes No Vonereal Disease Yes No Convulsions Yes No Heart Trouble/Disease Yes No Paychidit Care Yes No Vonereal Disease Yes No Vonereal	Г		•		_				
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs  Other If other, please explain:    Do you have, or have you had, any of the following?   AIDS/HIV Positive Yes No   Cortisone Medicine Yes No   Hempohilia Yes No   Radiation Treatments Yes No   Alzheimers Disease Yes No   Diabetes Yes No   Hepatitis A Yes No   Recent Weight Loss Yes No   Anaphylaxis Yes No   Drug Addiction Yes No   Hepatitis B or C Yes No   Renal Dialysis Yes No   Anemia Yes No   Emphysema Yes No   Herpes Yes No   Renal Dialysis Yes No   Radiation Treatments Yes No   Recent Weight Loss Yes No   Renal Dialysis Yes No   Renal Dialy	Pregnant/Trying to get pr			ontrace	ptives?	○Yes ○No Nursiı	ng?	0	
AIDS/HIV Positive	Aspirin Pe	enicillin	Codeine Local A			Acrylic	Metal	Latex Sulfa	Drugs
AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Radiation Treatments Yes No Alzheimers Disease Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No Anaphylaxis Yes No Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylaxis Yes No No Anemia Yes No Anemia Yes No Angina Yes No Recent Weight Loss Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Remail Dialysis Yes No No Herpes No Hert Note No Recent Weight Loss Yes No Recent Weight Loss No No Herpes No No Herpes No Recent Weight Loss No No No Note Note No No Note Note No No Herpes No No Herpes No Herpes No	Do you have or have you	, had any of th	ha fallowing?						
Alzheimers Disease Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anemia Yes No Easily Winded Yes No Herpes Yes No Renal Dialysis Yes No Remail	1	-	-	○ Voc	○No I	Hemonhilia	○Ves ○No	Padiation Treatments	○ Vec ○ No
Anaphylaxis						•			_
Anemia Yes No Easily Winded Yes No Herpes Yes No Rheumatic Fever Yes No Angina Yes No Emphysema Yes No High Blood Pressure Yes No Rheumatism Yes No Arthitis/Gout Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Artificial/Heart Valve Yes No Excessive Bleeding Yes No Artificial Joint Yes No Excessive Bleeding Yes No Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Blood Disease Yes No Frequent Cough Yes No Breathing Problem Yes No Frequent Headaches Yes No Bruise Easily Yes No Genital Herpes Yes No Cancer Yes No Glaucoma Yes No Congenital Heart Disorder Yes No Heart Murmur Yes No Convulsions Yes No Heart Trouble/Disease Yes No Convulsions Yes No Heart Trouble/Disease Yes No Parathyroid Disease Yes No Venereal Disease Yes No Convulsions Yes No Venereal Disease Yes No Yes No Venereal Disease Yes No Yes No Venereal Disease Yes No Yenereal Disease Yes No Y		_		_	_	•	_	•	
Angina			-	_	_	•	_	•	○ Yes ○ No
Arthitis/Gout						•			○ Yes ○ No
Artificial/Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Sickle Cell Disease Yes No Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Asthma Yes No Fainting Spells/Dizziness Yes No Irregular Heartbeat Yes No Sinus Trouble Yes No Sinus Yes No Sinus Trouble Yes No Sinus Trouble Yes No Sinus Trouble Yes No Sinus Trouble Yes No Venereal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No Sinus Yes No Venereal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No Sinus Trouble Yes No Venereal Disease Yes No Venereal Disease Yes No Yes No Venereal Disease Yes No Sinus Trouble Yes No Venereal Disease Yes No Yes N	•					-			○ Yes ○ No
Artificial Joint			· · · ·			•			○Yes ○No
Asthma			•						○Yes ○No
Blood Disease	Asthma		Fainting Spells/Dizziness	○Yes	○No		○Yes ○No	Sinus Trouble	○Yes○No
Breathing Problem	Blood Disease	○Yes ○No				Kidney Problems	○Yes ○No	Spina Bifida	○Yes ○No
Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes No Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes No Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tonsilitis Yes No Cold Sores/Fever Blisters Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes No Venereal Disease Yes No	Blood Transfusion	○Yes○No	Frequent Diarrhea	○Yes	○No	Leukemia	○Yes ○No	Stomach/Intestinal Disease	$\bigcirc$ Yes $\bigcirc$ No
Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes N Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tonsilitis Yes N Chest Pains Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tonsilitis Yes N Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes N Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes N	Breathing Problem	○Yes ○No	Frequent Headaches	○Yes	○No	Liver Disease	○Yes ○No	Stroke	$\bigcirc$ Yes $\bigcirc$ No
Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tonsilitis Yes No Chest Pains Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tuberculosis Yes No Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes No Venereal Disease	Bruise Easily	○Yes ○No	Genital Herpes	○Yes	○No	Low Blood Pressure	○Yes ○No	Swelling of Limbs	$\bigcirc  Yes  \bigcirc  No$
Chest Pains	Cancer	○Yes○No	Glaucoma	○Yes	○No	Lung Disease	○Yes ○No	Thyroid Disease	$\bigcirc  Yes  \bigcirc  No$
Cold Sores/Fever Blisters	Chemotherapy	○Yes ○No	Hay Fever	○Yes	○No	Mitral Valve Prolapse	○Yes ○No	Tonsilitis	$\bigcirc  Yes  \bigcirc  No$
Congenital Heart Disorder O Yes O No Heart Pacemaker O Yes O No Parathyroid Disease O Yes O No Venereal Disease O Yes O No O YES O	Chest Pains	○Yes ○No	Heart Attack/Failure	○Yes	○No	Osteoporosis	○Yes ○No	Tuberculosis	$\bigcirc  Yes \bigcirc  No$
Convulsions						Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
	"					•			○ Yes ○ No
Tellow Jauriulce 1es ON	Convulsions	○ Yes ○ No	Heart Trouble/Disease	○Yes	○No	Psychiatric Care	○ Yes ○ No		
Have you ever had any serious illness not listed above? OYes ONo If yes, please list:	Have you ever had any	serious illness	not listed above? OYe	s ONc	o If ye	s, please list:		Tellow Sauridice	
			stions on this form have l					ng incorrect information car	n be

\_\_\_ DATE \_\_\_

SIGNATURE OF PATIENT, PARENT or GUARDIAN \_\_\_\_\_