

Medical History [continued]

16. Abnormal blood pressure, excessive bleeding, or anemia? _____
17. Breathing problems, asthma, tuberculosis, or hay fever? _____
- _____
18. Cancer, X-ray treatments, chemotherapy, or IV bisphosphonate (i.e. Zometa or Aredia) treatment? _____
- _____
19. Diabetes? _____
20. Kidney problems or renal dialysis? _____
21. A stroke, convulsions, or fainting spells? _____
22. Tumors or growths? _____
23. Arthritis or rheumatism? _____
24. Have you ever had a major operation? _____ Is yes, describe. _____
- _____
25. Have you ever had a serious injury to your head or neck? _____ If yes, describe. _____
- _____
26. Are you on a special diet? _____ If yes, for what reason and describe. _____
27. Do you smoke? _____ If yes, describe type and quantity. _____
28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? _____ If yes, when and describe. _____
- _____
29. Do you consume any alcoholic beverages? If yes, how much and how often? _____
30. Are there any other problems about your health of which you are aware? _____
- _____
- _____
31. For children under 10 years old: Was the child born by Cesarean Section? _____
32. Females: Are you currently taking any bisphosphonate medication? _____
33. Have you had any prosthetic joint replacement? _____

Dental History

1. Name of previous dentist _____ Date of your last visit _____
2. Reason for your last visit (or series of visits) _____
3. Do you have any of your X-rays or dental records? _____
4. Chief dental complaint if any? _____
- In respect to any previous dental treatment have you:**
5. Ever fainted? _____
6. Had an allergic reaction? _____
7. Had abnormal bleeding? _____
8. Any other complications during or following dental treatment? _____ If yes, describe. _____
- _____