

• Medical Information •

Patient Name: _____

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p>(Check DK if you Don't Know the answer to the question)</p> <p>Are you now under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Physician Name: _____ Phone: <i>include area code</i> () _____</p> <p>Address/City/State/Zip: _____</p> <p>Are you in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Has there been any change in your general health within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>If yes, what condition is being treated? _____</p> <p>Date of last physical exam: _____</p>	<p>Yes No DK</p> <p>Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>If yes, what was the illness or problem? _____</p> <p>Are you taking, or have you recently taken, any prescription or over-the-counter medicine(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>																																																																																																																																																																																																																																																																																																								
<p>Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®), for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Date treatment began: _____</p>	<p>Yes No DK</p> <p>Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>If so, how interested are you in stopping? _____</p> <p>(Circle one) VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p>																																																																																																																																																																																																																																																																																																								
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<p>Are you allergic to or have you had a reaction to:</p> <p>To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Yes No DK</p> <p>Metals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Latex (rubber) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Hay fever/seasonal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>																																																																																																																																																																																																																																																																																																								
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type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td> Repaired CHD with residual defects</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> <p><i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i></p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>DK</th> <th></th> <th>Yes</th> <th>No</th> <th>DK</th> </tr> </thead> <tbody> <tr><td>Cardiovascular disease</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Mitral valve prolapse</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Angina</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pacemaker</td><td><input 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Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify _____																																																																																																																																																																																																																																																																																																					
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____																																																																																																																																																																																																																																																																																																					
Cancer/Chemotherapy/ Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infections _____																																																																																																																																																																																																																																																																																																					
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
Diabetes Type I or II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches / migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe/rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																		
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																						
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																						
Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																						
<p>Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Name of physician or dentist making recommendation: _____ Phone: _____</p>																																																																																																																																																																																																																																																																																																									
<p>Do you have any disease, condition, or problem not listed above that you think we should know about? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Please explain: _____</p>																																																																																																																																																																																																																																																																																																									

•Authorization •

I authorize Dr. Puntillo to perform diagnostic procedures and treatment, including the use of local anesthetic, as may be necessary for proper dental care.

I give Dr. Puntillo consent to the use of nitrous oxide (laughing gas) per my request.

To the best of my knowledge the patient and medical information is complete and correct.

Signature _____ Date _____

•Recertification •

I certify that there have been no health changes except as noted below:

Date _____ Change _____ Signature _____

Date _____ Change _____ Signature _____

Date _____ Change _____ Signature _____