Name: DOB:

1.Who is your primary physician? _____

2. Have you had a joint replacement? YES NO

If yes, what kind and when _____

3. Have you ever been hospitalized or had a major surgery? YES NO

If yes, please list with years. _____

_____

4. Have you ever had a serious head or neck injury? YES NO

5. Have you ever taken Fosamax, Boniva, Actonel, Zometa, Aclasta, Nerixia, Aredia or any other medications containing bisphosphonates? YES NO

If yes, please list medication and dates taken. _____

6. Have you ever taken any injectable medications? YES NO

If yes, please list medication and dates taken. _____

7. Have you ever taken Prolia, Xgeva or Denosumab? YES NO

If yes, please list medication and dates taken. _____

8. Are you taking any medications currently (including any OTC)? YES NO
If yes, please list medications below.

9. Women: Are you pregnant or nursing? YES NO

10. Are you allergic to any metals, medications or latex? YES NO

If yes, please list _____

11. Are you on a special diet? YES NO
12. Do you use tobacco? YES NO
13. Do you use controlled substances? YES NO

14. Do you have, or have you had, any of the following

AIDS/HIV □	Cortisone Medication □	Hemophilia □	Radiation Treatments □
Alzheimer's Disease □	Diabetes □	Hepatitis A □	Weight Loss □
Anaphylaxis □	Drug Addiction □	Hepatitis B or C □	Renal Dialysis □
High Blood Pressure □	Rheumatism □	Arthritis/Gout □	Epilepsy/Seizures □
High Cholesterol □	Artificial Heart Valve □	Excessive Bleeding □	Hives/Rash □
Shingles □	Artificial Joint □	Excessive Thirst □	Hypoglycemia □
Sickle Cell Disease □	Asthma □	Fainting/Dizziness □	Irregular Heartbeat □
Sinus Trouble □	Blood Disease □	Frequent Cough □	Kidney Problems □
Spina Bifida □	Blood Transfusion □	Leukemia □	Stomach Problems □
Breathing Problems □	Frequent Headaches □	Liver Disease □	Stroke □
Bruise Easily □	Low Blood Pressure □	Swelling of Limbs □	Cancer □
Glaucoma □	Lung Disease □	Thyroid Disease □	Chemotherapy □
Hay Fever □	Mitral Valve Prolapse □	Tonsillitis □	Chest Pains □
Heart Attack/Failure □	Osteoporosis □	Tuberculosis □	Cold Sores □
Heart Murmur □	Pain in Jaw Joints □	Tumors/Growths □	Congenital Heart Disease □
Heart Pacemaker □	Ulcers □	Heart Trouble/Disease □	Psychiatric Care □

Have you ever had any illness not listed above? _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X _____ Date:_____