bu taken any medication of please list name and dosage currently taking any medication of please list name and dosage ou ever taken bone loss proplease list name and dosage aware of having an allergical please specify	r drugs ge cation, ge evention ge ic (or a	during to drugs, properties of drugs dverse)	wo years?the past two years? pills or herbal remed such as Fosamax, reaction to any subsequences of the past five years?	dies, including r Actonel, Boniva	regular c a or oth	dosages o	of aspirin?	Yes Yes	No No No					
bu had any medical care were but taken any medication of please list name and dosage currently taking any medical currently taking any medication of taking any medical currently taking any medical currently taking any medical currently taking any medical currently taking any medication of taking any medica	r drugs ge cation, ge eventic ge ic (or a espital c u have	during to drugs, pon drugs dverse) during the had, or	the past two years? pills or herbal remed such as Fosamax, reaction to any sub the past five years?	dies, including r Actonel, Boniva	regular of a or other ication?	dosages o	of aspirin?	Yes Yes	No No					
bu taken any medication o blease list name and dosag currently taking any medi blease list name and dosag bu ever taken bone loss pro- blease list name and dosag a ware of having an allergi blease specify	ge	drugs, pon drugs dverse) during the had, or	such as Fosamax, reaction to any sub	dies, including r Actonel, Bonive estance or med	regular of a or other	losages o	of aspirin?sphonates?	Yes Yes	No					
currently taking any medicularse list name and dosagou ever taken bone loss problease list name and dosagou aware of having an allergicularse specify	cation, ge evention ge ic (or a espital c u have	dverse) during the	such as Fosamax, reaction to any sub	Actonel, Bonive	a or oth	er bispho	sphonates?	Yes						
ou ever taken bone loss problease list name and dosage aware of having an allerging blease specify	ge de control de contr	dverse) during th had, or	reaction to any sub	ostance or med	ication?				No					
aware of having an allergic blease specify bu been a patient in the ho e which of the following yo Surgery, Disease, Attack) Pain	spital output	during th	e past five years?					Yes						
ou been a patient in the hose which of the following your surgery, Disease, Attack) Pain	u have Yes	had, or				5. Are you aware of having an allergic (or adverse) reaction to any substance or medication?								
Surgery, Disease, Attack) Pain	Yes			ircie "yes" or "r				. Yes	No					
nital Heart Disease	Yes	NO	Ulcers			No	Hepatitis A B C (circle)	Yes	No					
	100	No	Diabetes		Yes	No	Venereal Disease	Yes	No					
	Yes	No	Thyroid Problems		Yes	No	A.I.D.S./H.I.V. Positive	Yes	No					
lurmur	Yes	No	Glaucoma		Yes	No	Cold Sores/Fever Blisters	Yes	No					
w Blood Pressure	Yes	No	Contact lenses		Yes	No	Blood Transfusion	Yes	No					
alve Prolapse	Yes	No	Emphysema		Yes	No	Hemophilia	Yes	No					
Heart Valve/Pacemaker	Yes	No	Chronic Cough		Yes	No	Sickle Cell Disease	Yes	No					
atic Fever	Yes	No	Tuberculosis		Yes	No	Bruise Easily	Yes	No					
/Rheumatism	Yes	No	Asthma		Yes	No	Liver Disease/Yellow Jaundice	Yes	No					
ne Medicine	Yes	No	Hay Fever/Allergy	/Hives	Yes	No	Neurological Disorders	Yes	No					
Ankles	Yes	No	Latex Sensitivity		Yes	No	Epilepsy or Seizures	Yes	No					
	Yes	No	Sinus Trouble		Yes	No	Fainting or Dizzy Spells	Yes	No					
pecial/Restricted)	Yes	No	Radiation Therapy	<i>y</i>	Yes	No	Nervous/Anxious	Yes	No					
I Joints (hip, knee, etc.)	Yes	No	Chemotherapy		Yes	No	Psychiatric/Psychological Care	Yes	No					
Trouble	Yes	No	Tumors		Yes	No	Cancer	Yes	No					
•									No					
olease list:								., Yes	No					
							•		No					
ed all questions to the respective health ca	e bes re pro	t of my	knowledge. Sl	nould further	r inforr	nation b	e needed, you have my	permis	sion to					
uardian Signature							Date							
T of the officer of t	Rheumatism e Medicine	Rheumatism Yes e Medicine Yes Ankles Yes Ankles Yes Cial/Restricted) Yes Upoints (hip, knee, etc.) Yes Couble	Rheumatism	Rheumatism Yes No Asthma Hay Fever/Allergy No Hay Fever/Allergy Ankles Yes No Latex Sensitivity Yes No Sinus Trouble Hecial/Restricted) Yes No Radiation Therapy Joints (hip, knee, etc.) Yes No Chemotherapy House or gained more than 10 pounds in the past year? Have or have you had any disease, condition, or problem not lease list: The Are you pregnant or think you could be pregnant? Youse birth control prescriptions? Hand the above information is necessary to provide all questions to the best of my knowledge. Signer and the above mealth care provider or agency, who may be although the respective health or medication.	Rheumatism Yes No Asthma e Medicine Yes No Hay Fever/Allergy/Hives Ankles Yes No Latex Sensitivity Yes No Sinus Trouble Yes No Radiation Therapy Joints (hip, knee, etc.) Yes No Chemotherapy Touble Yes No Tumors Ulost or gained more than 10 pounds in the past year? The past year or have you had any disease, condition, or problem not listed? The past year or have you pregnant or think you could be pregnant? YesNo use birth control prescriptions? The past year or provide me with the diall questions to the best of my knowledge. Should further prespective health care provider or agency, who may release not in my health or medication.	Rheumatism Yes No Asthma Yes e Medicine Yes No Hay Fever/Allergy/Hives Yes Ankles Yes No Latex Sensitivity Yes Yes No Sinus Trouble Yes Pecial/Restricted) Yes No Radiation Therapy Yes Yes No Chemotherapy Yes Yes No Tumors Yes Yes No Tumors	Rheumatism Yes No Asthma Yes No e Medicine Yes No Hay Fever/Allergy/Hives Yes No Ankles Yes No Latex Sensitivity Yes No Yes No Sinus Trouble Yes No Doints (hip, knee, etc.) Yes No Chemotherapy Yes No rouble Yes No Tumors Yes No Holost or gained more than 10 pounds in the past year? In ave or have you had any disease, condition, or problem not listed? It are you pregnant or think you could be pregnant? Yes Months No use birth control prescriptions? It and the above information is necessary to provide me with dental care in the dail questions to the best of my knowledge. Should further information be trespective health care provider or agency, who may release such informating in my health or medication.	Rheumatism Yes No Asthma Yes No Liver Disease/Yellow Jaundice Medicine Yes No Hay Fever/Allergy/Hives Yes No Neurological Disorders	Rheumatism Yes No Asthma Yes No Liver Disease/Yellow Jaundice Yes Medicine Yes No Hay Fever/Allergy/Hives Yes No Neurological Disorders Yes Ankles Yes No Latex Sensitivity Yes No Epilepsy or Seizures Yes No Sinus Trouble Yes No Fainting or Dizzy Spells Yes No Intercept Yes No Radiation Therapy Yes No Nervous/Anxious Yes No Nervous/Anxious Yes No Intercept Yes No Districted) Yes No Cancer Yes No Cancer Yes No Tumors Yes No Cancer Yes No Cancer Yes No Nervous Anxious Yes No Paychiatric/Psychological Care. Yes No Intercept Yes No Cancer Yes No Cancer Yes No Nervous Anxious Yes No Psychiatric/Psychological Care Yes No Intercept Yes No Cancer Yes No Cancer Yes No Cancer Yes No Nervous Anxious Yes No Nervous Anxious Yes No Nervous Anxious Yes No Nervous Anxious Yes No Psychiatric/Psychological Care Yes No United Yes No Cancer Yes No Cancer Yes No Nervous Anxious Yes					