MEDICAL QUESTIONNAIRE

Name ___________________________

Age: ______ ___________________________

Sex: ______ ___________________________

1. Have you been a patient in a hospital in the past two years? If so, for what were you hospitalized? ____ YES___ NO___
____

2. Are you now, or have you been under the care of a physician (including a psychiatrist) during the past two years? If so, for what were you treated? ______________________ YES___ NO___
____
____

3. List medicines or drugs you have taken during the past year and for what.

MEDICATION:	FOR WHAT:
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________

4. Have you taken cortisone or other hormone medications? If so, please list. YES___ NO___
____

5. Have you had any surgical procedures in the past? Describe surgery and name of surgeon. YES___ NO___
____
____

6. Have you had <u>a reaction</u> to <u>any medicine</u>? Example: penicillin, sulfa, codeine, Vicoden? List and describe. ________________________________ YES___ NO___
____

7. Do you have hay fever or <u>any allergies</u> (Including eggs or shellfish)? If so, describe. YES___ NO___
____
____
____

8. When you cut yourself or have a tooth extracted, do you bleed so much that you have to see a doctor to have it stopped? YES___ NO___

9. Have you ever had a reaction during, or following dental treatment or oral surgery? YES___ NO___

10. Do you faint easily? YES___ NO___

11. Have you gained or lost more than 15 pounds recently? YES___ NO___

12. Do you use tobacco products? ___NO ___YES Type__________ How Much________

13. Do you have any sores or growths in your mouth? YES___ NO___

14. Have you ever had any serious injuries to your face or jaws? Describe: _______________ YES___ NO___
____

15. Do you have any disease, condition or problem not listed above that you think we should know about?____ YES___ NO___

◄ **OVER** **OVER** ►

16. Have you had a blood transfusion within the last 7 years? YES___ NO___

17. Women: ARE YOU PREGNANT? YES___ NO___

18. Approximate **Weight**:__________ **Height**:_____________

19. Circle the name of any of the following, which you have had:

Stroke	Blood disease	HIV/AIDS/Autoimmune Disease
Heart problems	Rheumatic fever	Syphilis or Venereal disease
Heart attack	Anemia	Diabetes
Chest pain angina	Asthma	Seizures (Epilepsy)
Irregular heart beat	Shortness of breath	Cancer
Congenital heart disease	Emphysema	X-ray therapy for Cancer
Replacement of heart valve	Pneumonia	Chemotherapy for Cancer
Heart murmur	Tuberculosis	Ulcers
MVP (Mitral Valve Prolapse)	Hepatitis (Yellow Jaundice)	Nervous disorders
Congestive heart failure	Kidney or Bladder trouble	Alcohol abuse
High blood pressure	Thyroid disease	Drug abuse including marijuana
Arthritis	Sleep Apnea	Glaucoma

20. Are you taking or have you ever taken any of the following medications?

These medicines are used for osteoporosis and cancer chemotherapy treatment.

_____	Boniva	(Ibandronate sodium)
_____	Fosamax	(Aldendronate)
_____	Didrocal	(Etidronate)
_____	Didronel	(Etidronate)
_____	Actonel	(Risedronate)
_____	Aredia	(disodium pamidronate)
_____	Bondronat	(ibandronic acid)
_____	Bonefos	(sodium clodronate)
_____	Loron	(sodium clodronate)
_____	Zometa	(Zoledronic acid)

Additional remarks: ____

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____

Date: ________________ Signature of Patient or Responsible Party_______________________________

Updated:_______________ Signature:____

_______________ ____

_______________ ____