TAMBRINI FAMILY DENTISTRY

MEDICAL HISTORY

Have you ever been hospitalized or had a major operation? Yes ☐ No ☐

Have you ever taken medication for osteoporosis? Yes ☐ No ☐

Have you ever taken a bisphosphonate drug such as: Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Pamidronate (Aredia), Risedronate (Actonel, Actonel with Calcium), Tiludronate (Skelid), Zoledronic Acid (Relcast, Zometa)? Yes ☐ No ☐

Have you ever been treated with an intravenous bisphosphonate drug (Aredia or Zometra) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myloma or metastatic cancer? Yes ☐ No ☐

Have you ever had metastatic cancer, Pagets disease or bone cancer? Yes ☐ No ☐

Do you use tobacco products? Yes ☐ No ☐

Do you consume alcoholic beverages on a daily basis? Yes ☐ No ☐

Have you had any cardiac valves repaired or replaced? Yes ☐ No ☐

Have you had a history of infective endocarditis? Yes ☐ No ☐

Have you ever had a joint replaced? Yes ☐ No ☐

If pain medication is needed would you prefer us to avoid prescribing opiod-based drugs? Yes ☐ No ☐

What, if any, medications are you currently taking? Please list medication name, dosage (if known), and frequency:

_____

_____

_____

Are you allergic to any of the following?

☐ No Drug Allergies ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Metal
☐ Local Dental Anesthetics ☐ Sulfa Drugs ☐ Other (please specify) _____

Women: Are you?

Pregnant: ☐ Yes ☐ No Taking Oral Contraceptives: ☐ Yes ☐ No Nursing: ☐ Yes ☐ No

Do you have, or have you had, any of the following? ***(Please circle Y for YES and N for NO)***

AIDS/HIV Positive	Y N	Diabetes	Y N	Hemophilia	Y N	Psychiatric Care	Y N
Alzheimer's Disease	Y N	Emphysema	Y N	Hepatitis	Y N	Radiation Treatments	Y N
Anaphylaxis	Y N	Epilepsy or Seizures	Y N	High Blood Pressure	Y N	Renal Dialysis	Y N
Anemia	Y N	Excessive Bleeding	Y N	Hypoglycemia	Y N	Rheumatoid Arthritis	Y N
Angina	Y N	Fainting Spells/Dizziness	Y N	Irregular Heartbeat	Y N	Sickle Cell Disease	Y N
Arthritis/Gout	Y N	Frequent Cough	Y N	Leukemia	Y N	Sleep Apnea	Y N
Asthma	Y N	Glaucoma	Y N	Liver Disease	Y N	Spina Bifida	Y N
Cancer	Y N	Hay Fever/Seasonal		Low Blood Pressure	Y N	Stomach/Intestinal	
Chemotherapy	Y N	Allergies	Y N	Lung Disease	Y N	Disease	Y N
Chest Pain	Y N	Heart Attack	Y N	Lupus	Y N	Stroke	Y N
Cold Sores/Fever				Mitral Valve Prolapse	Y N	Swelling of Limbs	Y N
Blisters	Y N	Heart Murmer	Y N	Osteoporosis	Y N	Thyroid Disease	Y N
Congenital Heart							
Disease	Y N	Heart Pacemaker	Y N	Parathyroid Disease	Y N	Tuberculosis	Y N

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

To the best of my knowledge, the questions on this form have been accutately 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.

Signature of patient (parent or guardian)_____ DATE_____