Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.**

1. Has there been any change in

 your general health within the

 past year? Yes No 2. My last physical examination was

 on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Are you now under the care of a physician?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Have you had any serious illness,

 operation or been hospitalized in the

 past 5 years? Yes No

Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Are you taking any medications? Yes No

 **(IF YES PLEASE SPECIFY BELOW)**

6. Have you ever taken Aredia, Zometa, Fosamax, Actonel or Boniva? Yes No

Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Do you have a blood disorder? Yes No

Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you been treated for a tumor? Yes No

9. Are you taking Antiviral Medication Yes No

Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Are you allergic or have you had a reaction to:

 -Local anesthetics Yes No

 -Penicillin Yes No

 -Sulfa drugs Yes No

 -Metals Yes No

 -Aspirin Yes No

 -Hydrocodone Yes No

 -Codeine Yes No

 -Latex Yes No

 -Bleach Yes No

 -Fluoride Yes No

 -Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN**

11. Are you taking birth control? Yes No

12. Are you pregnant? Yes No

Expected Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Are you nursing? Yes No

14.Do you have or have you had any of the following diseases or problems? (PLEASE CIRCLE OR CHECK)

 -Congenital Heart Disease

 -Heart Transplant

 -Prosthetic Cardiac valve or repair

 -History of Infective Endocarditis

 -Damaged or Artificial Heart Valves

 -Heart Murmur

 -Rheumatic Heart Disease

 -Cardiovascular Disease

 -Heart Attack

 -Stroke

 -Osteoporosis

 -Cancer, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 -Asthma

 -Seizures

 -Diabetes Type 1 Type 2

 -Smoker

 -Chew Tobacco

 -Hepatitis A B or C

 -AIDS

 -HIV

 -Thyroid problems

 -Respiratory Problems

 -Stomach Ulcer

 -Kidney trouble

 -High Blood Pressure or Low Blood Pressure

 -STD

 -Herpes

 -Epilepsy

 -Fainting Spells

 -Liver Disease

 -Anemia

 -Back Problems

 -Drug Abuse, Alcohol Abuse or Addiction

 -Depression

 -Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_