**Please help us to know you better:**

This information is important for our records and your health. It will be considered confidential.

1. Circle any of the following which you have had:

| | | |
|---|---|---|
| Heart trouble | Emphysema | Hemophilia/Abnormal bleeding |
| Congenital heart lesions | Diabetes | Bruise easily |
| Cardiac pacemaker | Thyroid or adrenal disease | Arthritis |
| Heart murmur/MVP | Kidney or bladder disease | Dry mouth |
| High blood pressure | Epilepsy (seizures) | Herpes virus/Cold sores |
| Rheumatic fever | Tuberculosis | Cancer treatment |
| Angina (chest pain) | Liver disease/Hepatitis | STD |
| Artificial heart valve | Ulcers/Stomach problems | H.I.V. positive/ARC or AIDS |
| Artificial joint (hip, knee, etc.) | Glaucoma | Blood transfusions |
| Stroke | Sinus trouble | Swollen ankles |
| Cortisone treatment | Asthma | Psychiatric treatment |
| Anemia | Migraines | Drug addiction |

2. I have reviewed all of the above. I have circled any of the above that apply to me. Initials: __________
3. Are you allergic to any of the following:

| Circle: | Penicillin | Erythromycin | Tetracycline | Aspirin | Codeine | Latex |
|---|---|---|---|---|---|---|
| | Vicodin | Valium | Sulfa | Rubber | Acrylic | |
| | Other: ____________________________ | | | None of the above | | |

4. Have you been a patient in the hospital during the last two years? ........................................Yes No
5. Please list any medications you have taken during the past year? ............................................................................

   ..............................................................................................................................................................
6. Have you ever taken prescription medication for weight reduction (diet pills)? .......................Yes No
   If yes, circle any of these drugs you have taken: Fen-Phen (fenfluramine - phentermine)
   Pondimin (fenfluramine) Redux (dexfenfluramine)
7. If you have taken any of the above drugs, have you had a medical exam to ensure that your heart valves were not affected? ........................................................................Yes No
8. Are you taking or have you ever taken bisphosphonates (e.g. Fosamax or Zometa)?
9. (Women) are you pregnant now? If so, what month?......................................................................Yes No
10. (Women) are you taking oral contraceptives? ....................................................................Yes No
    (Be aware: Antibiotics may negate the effects of birth control pills)
11. Are you wearing contact lenses? .........................................................................................Yes No
12. Do you have spells of dizziness or fainting? .......................................................................Yes No
13. Have you ever had an injury to your face, neck or jaws? .....................................................Yes No
14. Do you have frequent or severe headaches? ......................................................................Yes No
15. Have you ever received radiation therapy to the head or neck? ...............................................Yes No
16. Do you have ear pain or pain in front of the ears? ...............................................................Yes No
17. Do you smoke or use tobacco? .........................................................................................Yes No
18. Do you drink alcohol daily? ...............................................................................................Yes No
19. Do you take any recreational drugs? ...................................................................................Yes No
20. Is there anything else that we should know about your health that has not been mentioned in this form? ...............................................................................................................Yes No

I hereby certify that the foregoing answers are true and complete, and to the best of my knowledge my health is accurately represented in the above statements.

Annual Update

| ______________________ | __________ | ________ | ________ | ________ | ________ | ________ |
|---|---|---|---|---|---|---|
| Patient signature | Initials | | | | | |
| ______________________ | __________ | ________ | ________ | ________ | ________ | ________ |
| Date | Date | | | | | |