

14. Do you have any other condition or disease you think the doctor should know about? Yes No
If so, describe: _____
15. Do you smoke or chew Tobacco? Yes No
If so, how much per day? _____ For how many years? _____
16. Is there any past history of alcohol or chemical dependency or emotional disorder? Yes No
17. Are you wearing contact lenses? Yes No
18. Do you have any removable dental appliances? Yes No
19. Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Denosumab)? Yes No
20. Are you taking any medications including diet pills, birth control, non-prescription, antiangiogenic drugs, supplements or vitamins;
(If "Yes," LIST IN CHART BELOW) Yes No

CURRENT MEDICATIONS (including any supplements and vitamins)

Name of Medication	Dosage	When is the Medication Taken	Purpose
Example: RX abc	5mg	2 times a day, morning & night	Ulcers

21. Do you have any allergies?(If "Yes", LIST IN CHART BELOW, INCLUDING ALLERGIES TO PEANUTS, SOY OR EGGS) Yes No

ALLERGIES

Name of Medication OR food product.	Reaction or Intolerance Experienced (symptoms, severity)

FOR WOMEN ONLY

22. Are you pregnant or is there any chance you might be pregnant? Yes No
23. Are you nursing? Yes No

I have read and understand the importance of a truthful and complete Health History to assist my doctor in providing the best care possible. I have the opportunity to discuss Health History with my doctor.

Date: _____ Patient's Signature: _____ Doctor's Initials _____

Office Use only- Medications Prescribed to Patient On Day of Surgery: