John R Burnett, III, DDS, MAGD

Name: _____ Date of last physical exam: _____

Do you have or have you ever had: (please circle)

Prosthetic joint	Yes	No	Pacemaker	Yes	No	HIV positive	Yes	No
Heart murmur	Yes	No	Hepatitis	Yes	No	Prolonged bleeding	Yes	No
Rheumatic fever	Yes	No	Diabetes	Yes	No	Stomach problems	Yes	No
Mitral valve prolapse	Yes	No	Epilepsy	Yes	No	Thyroid problems	Yes	No
High blood pressure	Yes	No	Mononucleosis	Yes	No	Fainting	Yes	No
Low blood pressure	Yes	No	Herpes	Yes	No	Circulatory problems	Yes	No
Cancer	Yes	No	Chest pain	Yes	No	Nervous problems	Yes	No
Leukemia	Yes	No	Shortness of breath	Yes	No	Anemia	Yes	No
Chemo treatment	Yes	No	Frequent thirst	Yes	No	Venereal disease	Yes	No
Radiation treatment	Yes	No	Jaundice	Yes	No	Tuberculosis	Yes	No
Jewelry allergy	Yes	No	Severe headaches	Yes	No	Kidney problems	Yes	No
Latex allergy	Yes	No	Bladder problems	Yes	No	Sinus trouble	Yes	No
Penicillin allergy	Yes	No	Liver problems	Yes	No	Chew tobacco	Yes	No
Amoxicillin allergy	Yes	No	Asthma	Yes	No	Smoke	Yes	No
Sulfa allergy	Yes	No	Glaucoma	Yes	No	Drink alcohol	Yes	No
Codeine allergy	Yes	No	Emphysema	Yes	No	Pregnant	Yes	No
Hydrocodone allergy	Yes	No	Arthritis	Yes	No	AIDS	Yes	No

Other allergies Yes No (please list if yes): _____

Yes No Do you require antibiotics before dental treatment due to heart problems or joint replacement?

Yes No Have you ever taken bisphosphonate for osteoporosis or bone cancer? (Fosamax, Actonel, Aredia, Zometa, Ostac, Benefos, Bidronel, Alvista, Forteo, Skelid, etc.)

Yes No Are you under a physician's care? For what reason? _____

Yes No Do you take any medications? If so, please list: _____

_____

Physician's name, address, and phone: _____

Serious illnesses and operations: _____

Anything else? _____

I certify that the above information is complete and accurate.

Patient's/Guardian's signature: _____Date: _____

_____

_____

_____

_____

_____

_____

Doctor's Signature: _____Date: _____