8. Have you had surgery or radiation treatment for a tumor, growth or other condition of your head or neck? .... YES NO

If yes, please list ______________________

9. Do you have any other disease, conditions, or problems not listed above? If yes, please explain .... YES NO

____

____

10. Are you taking or have you ever taken any of the following medications for any type of cancer, osteoporosis, or bone loss due to aging, Paget's Disease, or multiple myeloma? .... YES NO

If yes, please check the appropriate medication below:

Non-Nitrogen Containing (less potent) Bisphosphonates – Oral
- Etidronate (Didronel, Didrocal)
- Tiludronate (Skelid)

Nitrogen Containing Bisphosphonates – Oral
- Pamidronate (Aredia, Rhoxal)
- Zoledronate (Zometa, Aclasta, Reclast)
- Clodronate (Bonefos)
- Neridronate

Nitrogen Containing Bisphosphonates – IV
- Alendronate (Fosamax, Fosamax +D, Fosavance)
- Ibandronate (Boniva, Bondronat)
- Risedronate (Actonel)
- Olpadronate

(This list of Bisphosphonate medications should not be considered complete as new drugs are continually being developed.)

11. Please list any medications, pills, or drugs with the dosage which you are taking both prescription and nonprescription:

Trade Name	Generic Name	Dose/Frequency	Reason

12. Have you had any trouble associated with previous dental treatment? .... YES NO

13. Do you have any lumps or sores in your mouth now? .... YES NO

14. Do you smoke or use smokeless tobacco? .... YES NO

15. How often do you have dental checkups? ______________ Date of last exam ______________

16. WOMEN ONLY: Are you pregnant? .... YES NO

If yes, when is your expected due date? ______________

I certify that I have read and understand the above. I acknowledge that I have answered these questions accurately and completely.

PATIENT SIGNATURE: ______________ DATE SIGNED: ______________

If a family member or designated caretaker has helped in filling out this form, please sign: ______________