Keystone Rural Health Consortia, Inc.

Johnsonburg Dental Center
81 Clarion Road
Suite # 2
Johnsonburg, PA 15845

Cameron County Dental Center
90 East Second Street
PO Box 270
Emporium, PA 15834

Date: ______________________

Name: __________________________________

Reason for Visit: ____

Allergies: ____

Do you use tobacco? ___Yes ___No   Are you currently pregnant or could be? ___Yes ___No

Please mark any current or past medical problems below:

Cardiovascular:

___Heart Attack ___Angina ___Chest Pain ___High Blood Pressure ___Low Blood Pressure
___Stent ___Rheumatic Fever ___Arrhythmias ___Coronary Bypass ___Pacemaker/Defibrillator
___Heart Murmur ___Bypass ___Artificial Heart Valve Other:________________________________

Respiratory:

___Asthma ___Emphysema ___Chronic Obstructive Pulmonary Disease ___Chronic Cough
___Tuberculosis ___Breathing Difficulties ___Dysphagia (Difficulty Swallowing)
___Pneumonia or History of Aspiration Pneumonia Other Please Specify:_________________________

Gastrointestinal:

___Ulcers ___Irritable Bowel ___Reflux ___Colitis ___Hepatitis A ___Hepatitis B
___Hepatitis C Other Please Specify:____

Musculoskeletal:

___Arthritis ___Rheumatoid Arthritis ___Rheumatism ___Osteo-Arthritis ___Osteoporosis
___Artificial Joint/Prosthetic Device Other Please Specify:______________________________________

Neurological:

___Fainting ___Dizziness/Light Headed ___Epilepsy ___Vertigo ___Depression ___Stroke
___Bipolar ___Seizures ___Multiple Sclerosis ___ADHD ___Parkinson's Disease
___Vision Other Please Specify: ____

Endocrine:

___Diabetes-Diet Controlled ___Diabetes-Controlled by Medications ___Diabetes-Insulin Dependent
___Hypoglycemia (Low Blood Sugar) ___Hyperglycemia (High Blood Sugar) ___Thyroid Gland Disorder
___Adrenal Gland Disorder ___Hormone Replacement Therapy
Other Please Specify:____

Immune:

___HIV/AIDS ___Auto-Immune Disorder (Please Specify):__________________________________
Other Please Specify:____

Do you have a history of cancer (please specify): ____

Have you ever been instructed to premedicate before dental treatments? ___YES ___NO

Have you ever taken an oral bisphosphonate? ___YES ___NO
If yes please Circle which one of the following:
Actonel Boniva Fosmax Didronel Aredia Zometa Other Please Specify:_______________