SUPPLEMENTAL MEDICAL HISTORY
(EXTRACTIONS)

1. Have you ever had any of the following complications?
   a. Angina (chest tightness) diagnosis ? Y/N _________
   b. Stroke? Y/N _________
   c. Heart attack? Y/N __________
   d. Bypass surgery? Y/N _________
   e. Heart valve replacement(s)? __________
   f. High blood pressure? Y/N _________
   g. Any history of bacterial endocarditis (heart infection)? Y/N _________
2. Any complications whatsoever with **excessive bleeding?** Y/N ________
   i. Are you taking any of the following medication(s)? If yes, please list the date and time you last took your prescribed dosage.
      1. Warfarin/Coumadin? Y/N ________
      2. Plavix/Clopidogrel? Y/N ________
      3. Heparin? _________
      4. Aspirin? Y/N _______
      5. Xarelto (Rivaroxaban)? Y/N _______
      6. Pradaxa (Dabagatran)? Y/N ________
      7. Eliquis (Apixaban)? Y/N ________
3. Have you ever been diagnosed as having **Diabetes Mellitus (**Type 1 or 2) Y/N__________
   a. Please indicate type I or type II: __________
   b. If yes, please answer the following:
      i. Date/Time of last "fasting blood glucose" reading:
         1. Time: ____________
         2. Date: _____________
         3. Number on reading: ____________
   c. Measurement of your last Hemoglobin A1C test:
      i. Number: __________
      ii. Date: ____________
   d. Have you had anything to eat today (within last 4 hours)? Y/N _________
   e. Have you ever had any trouble healing from surgeries? Y/N _________
4. Have you ever been diagnosed with **adrenal insufficiency** (Addison's Disease)? Y/N ____________
5. Are you currently undergoing any type of renal (kidney) dialysis? Y/N ________
6. Have you ever been diagnosed with **sickle cell anemia**? Y/N ____________
7. Have you ever been diagnosed with any of the following:

   a. **Acute leukemia**? Y/N ___________
   b. **Lymphoma** (of any type)? Y/N ___________
   c. **Cytotoxic chemotherapy**? Y/N ___________
   d. **Bone marrow transplant?** Y/N ___________

8. Have you ever had any of the following conditions?
   a. **Hepatitis** (of any type? Y/N __________
      i. If yes, please indicate the following:
         1. Type: __________ (A, B, C, D, or E)
         2. Date of diagnosis: ___________
         3. Current stage of disease: ___________
   b. **Cirrhosis** Y/N? __________
   c. **Alcoholic hepatitis** Y/N? __________
   d. **Von Willebrand clotting disorder?** Y/N __________
   e. **Hemophilia of any type?** Y/N __________
9. PREGNANCY
   a. FEMALES ONLY: Is it possible that you may be currently pregnant, or do you know that you are currently pregnant? Y/N __________
10. BISPHOSPHONATE DRUGS:
   a. Have you ever been diagnosed with osteoporosis? Y/N ______
   b. Have you ever been diagnosed with Paget's disease? Y/N ______
   c. Have you ever been diagnosed with cancer of any type? Y/N ______
      i. If you answered yes to having previously been diagnosed with ANY type of cancer, please give us more information so that we can treat you more effectively:
         1. Type of cancer: _____________________________
         2. Stage of cancer: _____________________________
         3. Is the cancer still existing? ____________________
      ii. Have you ever had any radiation therapy or chemotherapy as treatment for the cancer? Y/N ___________
         1. If yes, last date of the therapy ___________
      iii. Are you currently taking ANY of the following bisphosphonate drugs?
         1. **Fosamax** (Alendronate)? Y/N _________
         2. **Reclast** (Zoledronic acid)? Y/N _______
         3. **Boniva** (Ibandronate)? Y/N ________
         4. **Didronel** (Etidronate)/? Y/N ________
         5. **Actonel** (Risedronate)? Y/N ________
         6. Any other bisphosphonate drug not listed here? Y/N ________
            a. If yes, please list the name of the drug. ______________

11. STEROIDS:
    a. Are you undergoing any treatment that requires you to take steroids (a common one is Prednisone) as prescribed by your physician? Y/N _________
12. THYROID:
    a. Have you ever been diagnosed with "hyperthyroidism?" Y/N __________
    b. Are you taking any medications for "hypothyroidism?" Y/N __________
        i. If yes, please list the medication: _________________
13. SMOKING:
    a. Do you currently smoke cigarettes/cigars/or any other item(s) that require you to inhale? Y/N __________
14. DRUGS:
    a. Have you ever taken any of the following drugs?
        i. Marijuana? Y/N ___________
        ii. Crystal Methamphetamine? Y/N ________
        iii. Cocaine or "Crack?" Y/N ________
        iv. Heroin? Y/N ________

NOTE: As a patient, you are protected by HIPPA so that any information you share with us is absolutely confidential (between you and your treatment provider(s)). It is not our intention to share your private information with anyone. The reason we ask the questions above is to customize your treatment to best fit you. Many drugs/conditions can potentially interfere with the medications or treatments we provide. It is of utmost importance that you are 100% honest with us about any of the conditions/medications you are currently experiencing or taking. We are here to treat you to the best of our abilities. If you have any other concerns, please do not hesitate to bring them up.

<u>Please sign below indicating you have disclosed all information required in this form to the best of your ability</u>.

Name: ______________________________
Signature: ___________________________
Date: _______________________________