

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

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|--|--|--|--------------------------|--------------------------|--------------------------|---|------------------|--|--------------------------|--------------------------|--------------------------|
| (Check DK if you Don't Know the answer to the question) | | | Yes No DK | | | | Yes No DK | | | | |
| Do you wear contact lenses? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you use controlled substances (drugs)?..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you use tobacco (smoking, snuff, chew, bidis)? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Date: _____ If yes, have you had any complications? _____ | | | | | | If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED | | | | | |
| Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcoholic beverages? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If yes, how much alcohol did you drink in the last 24 hours? _____ | | | | | |
| Date Treatment began: _____ | | | | | | If yes, how much do you typically drink in a week? _____ | | | | | |
| Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction. | | | Yes | No | DK | | | | Yes | No | DK |
| Local anesthetics _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Metals _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Latex (rubber) _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other antibiotics _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Iodine _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates, sedatives, or sleeping pills _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever/seasonal _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa drugs _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Animals _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine or other narcotics _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Food _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. | | | | | | | | | | | |
| | | | Yes | No | DK | | | | Yes | No | DK |
| Artificial (prosthetic) heart valve | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune disease | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Previous infective endocarditis | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Damaged valves in transplanted heart | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Systemic lupus erythematosus. | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart disease (CHD) | | | | | | Asthma | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Unrepaired, cyanotic CHD | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Repaired (completely) in last 6 months | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Repaired CHD with residual defects | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Tuberculosis | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i> | | | | | | Cancer/Chemotherapy/ Radiation Treatment | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Yes | No | DK | Chest pain upon exertion | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiovascular disease. | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic pain | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Type I or II | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arteriosclerosis | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Congestive heart failure | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Malnutrition | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Damaged heart valves | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal disease | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | G.E. Reflux/persistent heartburn | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Low blood pressure | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other congenital heart defects | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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