LOWMAN FAMILY DENTAL
PO Box 292
501 Empire Street
Holmen WI 54636-5000

(608)526-4707
contactus@lowmanfamilydental.com
www.lowmanfamilydental.com

First Name/Last Name/DOB:

Physician's Name/Date of last visit:

* Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

* ◯ Yes ◯ No

Have you ever taken any of the group of drugs collectively known as"Bisphosphonates"? i.e. Zometa (zoledronic acid), Aredia (pamidronate), Fosamax (alendronate), Actonel (risedronate) and Boniva (ibandronate).

* ◯ Yes ◯ No

Have you had any serious illnesses or operations?

* ◯ Yes ◯ No

If yes, please explain?

*

Have you ever had a blood transfusion?

* ◯ Yes ◯ No

Are you currently taking blood thinners?

* ◯ Yes ◯ No

(Women) Are you pregnant and/or nursing?

* ◯ Yes ◯ No

(Women) Are you taking birth control?

* ◯ Yes ◯ No

List of medications you are currently taking:
Pharmacy Name/ Phone Number:

*

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Check if you have or have had any of the following:

* ☐ Anemia	☐ Arthritis, Rheumatism	☐ Artificial Heart Valves
☐ Artificial Joints	☐ Asthma	☐ Back Problems
☐ Blood Disease	☐ Cancer	☐ Chemical Dependency
☐ Chemotherapy	☐ Circulatory Problems	☐ Cortisone Treatments
☐ Cough up Blood	☐ Diabetes: Type I Type II	☐ Cough,Persistant
☐ Epilepsy	☐ Fainting	☐ Glaucoma
☐ Headaches	☐ Heart Murmur	☐ Heart Problems
☐ Hemophilia	☐ Hepatitis	☐ High Blood Pressure
☐ HIV/AIDS	☐ Jaw Pain	☐ Kidney Disease
☐ Liver Disease	☐ Mirtral Valve Prolapse	☐ Pacemaker
☐ Radiation Treatment	☐ Respiratory Disease	☐ Rheumatic Fever
☐ Scarlet Fever	☐ Shortness of Breath	☐ Skin Rash
☐ Stroke	☐ Swelling of Feet or Ankles	☐ Thyroid Problems
☐ Tobacco Habit	☐ Tonsillitis	☐ Tuberculosis
☐ Ulcer	☐ Venereal Disease	

Check if you have any of the following Allergies:

* ☐ Aspirin	☐ Amoxicillin/Penicillin
☐ Barbiturates (sleeping pills, anti-anxiety)	☐ Codeine
☐ Local Anesthetic	☐ Sulfa
☐ Latex	☐ Other

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I acknowledge that it is my responsibility to inform my dental provider of any changes in my medical status.

Signature: _____ Date: _____

Response Date: _____