7. (Women) Are you pregnant? ..... **YES** **NO**
   Expected Delivery Date _____
8. (Women) Do you have a history of previous miscarriages? ..... **YES** **NO**
9. (Women) Are you taking birth control pills? (Antibiotics may nullify effective contraception)..... **YES** **NO**
10. Are you allergic to, or have had any unusual reaction to any of the following medications? **YES** **NO**

___ Erythromycin
___ Sulfa Drugs
___ Other Antibiotics: _____
___ Codeine
___ Aspirin
___ Other Pain Medications: _____
___ Penicillin
___ Local Anesthetics
___ Epinephrine
___ Barbiturates
___ Sleeping Pills
___ Other: _____

11. Any other allergies or hives? _____
    Sinus Trouble? _____
12. Have you ever been advised not to take a particular medication? ..... **YES** **NO**
    If yes, please list: _____
13. Have you ever been advised to take antibiotics before dental treatment? ..... **YES** **NO**
14. Have you ever taken Bisphosphonates such as Boniva, Actonel, or Fosamax? ..... **YES** **NO**
15. Please indicate if you are taking any of the following medications:

___ Heart Medication
___ Blood Pressure Medication
___ Nitroglycerine
___ Inderal
___ Antibiotics
___ Sedatives
___ Anti-anxiety
___ Pain Medication
___ Cortisone (Steroids)
___ Thyroid
___ Other Medications
___ Alcohol: ___ drinks per day
___ "Recreational" drugs such as cocaine, marijuana, stimulants, or depressants

Name	Purpose	Frequency

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice.

Signature _____ Date _____

116 Wayland Avenue · Providence, Rhode Island 02906
(401) 861-1343 · Fax: (401) 453-1343 · www.DrBarbaraBilder.com · Info@DrBarbaraBilder.com