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Patient Name (print): _____ Date: ____ / ____ / ____
Last First M.I.

Are you taking or have you ever taken Bisphosphonates? NO YES

If YES, name of medicine:_____

Dosage: _____

Administered by: I.V. Pill Form

Are you Diabetic? NO YES, type: _____

If YES, name of medicine:_____

Dosage: _____

Do you smoke? NO YES

If YES, how frequent (daily average): _____