



Patient Name: _____
 Address: _____
 Name of Parent (If under 18): _____
 Phone: _____ Cell: _____
 Pharmacy: _____

Date of Birth (MM/DD/YY): _____
 Dental Insurance: _____
 Primary Care Provider: _____
 Provider Phone #: _____
 Date of Last Medical Exam: _____

Are you under the care of a Physician:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please list date of last visit:
Have you had to stay in the hospital in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please list what date and reason:

Have you had any of the following diseases or problems?	Yes	No	
1. Active Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please indicate date of diagnosis:
2. Cough for longer than 3 weeks or a current fever	<input type="checkbox"/>	<input type="checkbox"/>	
3. Cough that produces blood	<input type="checkbox"/>	<input type="checkbox"/>	

>>>> If you answered "YES" to questions 1, 2 or 3 above please stop and return this form to the receptionist<<<<

Are you allergic or have you had a bad reaction to any of the following:					
	Yes	No		Yes	No
Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Cloves	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Latex (rubber)	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, Sedatives, Sleeping Pills	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	
Are you taking any medication? <i>Including: Prescriptions, Over the Counter Medications, Herbs, Vitamins, Etc.</i>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list your medications:

DO YOU...	Yes	No	HAVE YOU...	Yes	No
Use Recreational Drugs (Past or Present)? If yes, what type _____	<input type="checkbox"/>	<input type="checkbox"/>	Been on any antiresorptive medication or agents (Bisphosphonates) to treat Osteoporosis or other skeletal complications? (ex. Fosomax, Actonel, Atelvia, Boniva, Reclast, Prolla, Aredia, Zometa, XGEVA)	<input type="checkbox"/>	<input type="checkbox"/>
Use Alcohol: If Yes, how many drinks per week? _____	<input type="checkbox"/>	<input type="checkbox"/>			
Use Tobacco? Chew <input type="checkbox"/> Smoke <input type="checkbox"/> If Yes, how many packs/day? _____	<input type="checkbox"/>	<input type="checkbox"/>			
Have any bleeding issues or on a blood thinner? (Coumadin, Warfarin, Plavix, Aggrenox, Heparin, Levonox, Prodaxa)	<input type="checkbox"/>	<input type="checkbox"/>	Had cobalt, radium, radiation therapy or chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>

****PLEASE CONTINUE TO THE BACK OF THIS FORM****

Do you have or have you had any of the following diseases or problems?

	Yes	No		Yes	No		Yes	No
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Oral Sores/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Aids/HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Urination	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Pre-medicate before Dental Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Angina (Chest Pain)	<input type="checkbox"/>	<input type="checkbox"/>	Gastric Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Problems after Dental Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Autistic Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice, Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker or Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type I <input type="checkbox"/> Type II <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

Only Heart Conditions Requiring Antibiotic Prophylaxis:	Yes	No	WOMEN ONLY	Yes	No
Artificial Prosthetic Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Are you possibly pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Previous Infective Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, what's the expected due date:		
Damaged Valves in Transplanted Heart	<input type="checkbox"/>	<input type="checkbox"/>	Are you Nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, Cyanotic Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking Birth Control Pills?	<input type="checkbox"/>	<input type="checkbox"/>
Completely repaired Congenital defect in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>			
Repaired Congenital defect with residual effects	<input type="checkbox"/>	<input type="checkbox"/>			

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately and completely answered. I understand that providing incorrect or misleading information can be dangerous to my health. I am also aware that the clinic should be informed of all my health changes.

Patient/Parent/Guardian Signature

Date

Doctor Signature

Date