**Patient Name:** ______________________ ______________________ ___ ______________
Last First MI Preferred Name

**What is your date of birth?** __________

**Who is your family Physician?**

______________________________________________________________________

______________________________________________________________________

**Please list ALL medications that you are currently taking.**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Are you taking Blood Thinners of any kind? Including daily Aspirin** ◯ Yes ◯ No

**If you take Asprin, please check one of the following:**

☐ 81mg ☐ 325mg

**Are you currently seeing a pain management doctor?** ◯ Yes ◯ No

**Are you allergic to:**

☐ ASPIRIN ☐ ERYTHROMYCIN ☐ CODEINE ☐ LATEX ☐ SULFA ☐ PENICILLIN ☐ TETRACYCLINE

☐ NONE

**List other drug or medicine allergies.** ______________________

**Have you had any serious illnesses or operations in the last 5 years? Explain:**

______________________________________________________________________

______________________________________________________________________

**Have you ever had a REACTION TO ANY DENTAL TREATMENT OR ANESTHETIC?** ◯ Yes ◯ No

**Do you have any condition that requires Pre-Medication before dental treatment? Such as ARTIFICAL JOINTS OR STENTS?**

☐ Artificial Joints ☐ Stents ☐ Heart Surgery

**Have you taken high dose Steroids in the last 6 months?** ◯ Yes ◯ No

**Do you use TOBACCO products?** ◯ Yes ◯ No

**If yes what kind?**

☐ Cigarette ☐ Chew ☐ Vape

**How long?** ______________________

**Have you taken or are you taking any medication for osteoporosis?**

◯ AREDIA ◯ ZOMETA ◯ ACTONEL ◯ BONIVA ◯ FOSAMAX ◯ SKELIF ◯ RELCAST ◯ DIDRO

**Please mark if your have any of the following:**

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV | ☐ ANAPHYLAXIS | ☐ ANEMIA | ☐ ARTIFICAL VALVES | ☐ ASTHMA |
| ☐ ATRIAL FIBRILLATION | ☐ AUTO IMMUNE DX | ☐ BELL'S PALSY | ☐ BLOOD CLOTS | ☐ BLOOD DISEASE |
| ☐ BREATHING PROBLEMS | ☐ CANCER | ☐ CROHN'S DISEASE | ☐ DEPRESSION | ☐ DIABETES |
| ☐ DRUG ADDICTION | ☐ EPILEPSY/SEIZURES | ☐ FAINTING | ☐ FIBROMYALGIA | ☐ GLAUCOMA |
| ☐ HEART MURMUR | ☐ HEART PROBLEMS | ☐ HEART STENTS | ☐ HEPATITIS A B C | ☐ HIGH BLOOD PRESSURE |
| ☐ KIDNEY DISEASE | ☐ LIVER DISEASE | ☐ LUPUS | ☐ MITRAL VALVE PROLAPSE | ☐ NERVOUS DISORDERS |
| ☐ PACE MAKER | ☐ RADIATION THERAPY | ☐ REFLUX | ☐ RHEUMATIC FEVER | ☐ RHEUMATOID ARTHRITIS |
| ☐ STROKE | ☐ THYROID DISEASE | ☐ VENEREAL DISEASE | | |

**Have you had any illness not listed above?**

________________________________________________________________________

________________________________________________________________________

**ARE YOU PREGNANT?** ◯ Yes ◯ No

**ARE YOU NURSING?** ◯ Yes ◯ No

**ARE YOU TAKING BIRTH CONTROL PILLS?** ◯ Yes ◯ No

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**Response Date:** ___________