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Patient Name: _____ _____ ____ _____

Last First MI Preferred Name

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ *Pre Medicate	☐ Acid Refulx/Ulcers	☐ allergy	☐ Allergy-Codeine
☐ Allergy-Drug	☐ Allergy-Latex	☐ Allergy-Penicillin	☐ Allergy-Seasonal
☐ Allergy-Sulfa Drug	☐ Alzheimer's/Dementia	☐ Anemia	☐ Arthritis/Rheumatism
☐ Aspirin Allergy	☐ Asthma	☐ Autoimmune Disease	☐ Blood Disease
☐ Blood Pressure-High	☐ Blood Pressure-Low	☐ Blood Thinners	☐ Cancer
☐ Chemotherapy	☐ Diabetes Type I/II	☐ Emphysema/COPD	☐ Epilepsy/Seiaures
☐ Excessive Bleeding	☐ Fainting/Dizziness	☐ Glaucoma	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C
☐ High Cholesterol	☐ HIV/AIDS	☐ Hypoglycemia	☐ Joint Replacement
☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders	☐ Mitral Valve Prolaps
☐ Multiple Sclerosis	☐ Nervous Disorders	☐ Neuro. Disorder	☐ Organ Transplant
☐ Other	☐ Pacemaker	☐ Parkinsons Disease	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ STD/HPV	☐ Stroke/TIA
☐ Surgical Implants	☐ Thyroid Condition	☐ Tuberculosis	☐ Tumors/Growths

☐ Pregnant/Planning Pregnancy/Nursing

Please clarify the conditions or alerts selected including due date if pregnant:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain. * ◯ Yes ◯ No

Pre-Med

_____

_____

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

_____

_____

Name of physician and date of last physical exam

_____

_____

Name and phone number of preferred pharmacy

_____

_____

Are you taking any medications (prescription and Non-prescription) if yes please explain below * ◯ Yes ◯ No

Medications

Have you taken Viagra, Revatio, Cialis or Lavitra in the last 24 hours?

Have you ever taken any medications with Biophosphonates? (Fosamax, Boniva, Actonel, or others)

Have you ever had an orthopedic total joint (hip, knee, elbow or finger) replacement?

Do you have any allergies and/or allergies to medications not previously listed. If yes, please explain below * ◯ Yes ◯ No

Allergies

* **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. I further consent to the performing of xrays and oral examinations. This will serve as my electronic signature.**

Name of Patient/Parent or Guardian completing this form *

Response Date: _____