Last Name: First Name: Birthdate:

Name of Medical Doctor:_____ City/State:_____

Emergency Contact_____ Phone _____ Relationship_____

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? ❑Yes ❑No

If yes, please list: _____

_____

Are you currently taking any medications, drugs or pills? ❑Yes ❑No

If yes, please list name and dosage: _____

_____

_____

_____

Do you use tobacco? ❑Chew ❑smoke How often? _____ How long? _____

Unusual reaction to dental injections?_____

Reason for today's visit_____ Are you in pain?_____

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old?_____

Do you have BiteWing x-rays that are less than 1 year old?_____

AIDS	❑Yes ❑No	Heart condition	❑Yes ❑No
Alcoholism	❑Yes ❑No	Heart murmur	❑Yes ❑No
Allergies or hives	❑Yes ❑No	Heart pacemaker	❑Yes ❑No
Asthma	❑Yes ❑No	Heart surgery	❑Yes ❑No
Arthritis/Rheumatism	❑Yes ❑No	Hemophilia	❑Yes ❑No
Artificial heart valve	❑Yes ❑No	Hepatitis type ____	❑Yes ❑No
Artificial joints-type _____	❑Yes ❑No	High blood pressure	❑Yes ❑No
Bleeding/Blood disorder	❑Yes ❑No	HIV positive	❑Yes ❑No
Blood thinners/Aspirin	❑Yes ❑No	HPV	❑Yes ❑No
Bone disease or bone cancer	❑Yes ❑No	Kidney trouble	❑Yes ❑No
Bruise easily	❑Yes ❑No	Latex sensitivity	❑Yes ❑No
Cancer	❑Yes ❑No	Liver disease	❑Yes ❑No
Chemotherapy	❑Yes ❑No	Milk/Casein allergy	❑Yes ❑No
Chest pain (Angina)	❑Yes ❑No	Mitral valve prolapse	❑Yes ❑No
Chronic cough	❑Yes ❑No	Neurological disorders	❑Yes ❑No
Cold sores/Fever blisters	❑Yes ❑No	Nervous/Anxious	❑Yes ❑No
Congenital heart disease	❑Yes ❑No	Osteoporosis	❑Yes ❑No
Contact lenses	❑Yes ❑No	Psychiatric/Psychological care	❑Yes ❑No
Cortisone medicine	❑Yes ❑No	Radiation therapy	❑Yes ❑No
Diabetes: Type _____	❑Yes ❑No	Rheumatic fever	❑Yes ❑No
Drug addiction	❑Yes ❑No	Sinus trouble	❑Yes ❑No
Emphysema	❑Yes ❑No	Sleep apnea/Snoring	❑Yes ❑No
Epilepsy or seizures	❑Yes ❑No	Stroke	❑Yes ❑No
Fainting or dizzy spells	❑Yes ❑No	Thyroid problems	❑Yes ❑No
Family history of diabetes	❑Yes ❑No	Tuberculosis (T.B.)	❑ Yes ❑No
Glaucoma	❑Yes ❑No	Tumors	❑Yes ❑No
Heart attack	❑Yes ❑No	Ulcers/Reflux	❑Yes ❑No

Premedication Required: ❑**Yes** ❑**No** _____

Any disease, condition or problem not listed: _____

<u>Women</u>

Are you pregnant or planning a pregnancy? ❑Yes ❑No

If yes, due date: _____

Are you a nursing mother? ❑Yes ❑No

Are you taking birth control pills? ❑Yes ❑No

Patient Name (Please Print) _____

Patient/Parent signature _____ **Date** _____

Doctor Signature _____ **Date** _____