**PATIENT NAME** _____

**ADDRESS** _____

_____

**DATE OF BIRTH** _____

---

**Do you have or have you ever had any of the following?**

- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ HEART DISEASE
- ☐ Heart Murmur/Defect
- ☐ Hormonal
- ☐ Herpes/Veneral Disea
- ☐ High Blood Pressure
- ☐
- ☐ Hypoglycemia
- ☐
- ☐
- ☐ Infectious Disease
- ☐ Immunocomprised
- ☐ Irregular Heart Beat
- ☐ Irritable Bowel Syn.
- ☐ Joint Replacement
- ☐ Kidney Disease

- ☐ Mental Disease
- ☐ Migraine/Headaches
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation or Chemo
- ☐ Respiratory/Asthma
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ TMJ
- ☐ Transplant
- ☐ Tuberculosis
- ☐ Tumor/Neoplasms
- ☐ Thyroid
- ☐ Ulcers
- ☐ Glaucoma
- ☐ Recurrent Sinus Infe
- ☐ Hrt Bypass/Stent
- ☐ Hepatitis A,B, or C
- ☐ PREGNANT- NOW
- ☐ Other_____

**Are you allergic to any of the following?**

**Allergies**

- ☐ LATEX
- ☐ Pen/Amoxil
- ☐ Erythromycin
- ☐ Cleocin
- ☐ Sulfa
- ☐ Narcotics/Pain Meds
- ☐ Codeine
- ☐ Ibuprofen/Motrin
- ☐ Tylenol
- ☐ Aspirin
- ☐ Hydrocodone
- ☐ Demerol
- ☐ Valium
- ☐ Local Anes/EPI
- ☐ Metal
- ☐ Iodine/Dye
- ☐ Pineapple
- ☐ Nitrous Oxide
- ☐ Gen. Anesthesia
- ☐ Other_____

**Do you take any medications?**

**Medications**

- ☐ No Medications
- ☐ Antibiotic
- ☐ Pain Medicine
- ☐ Heart Medicine
- ☐ Aspirin
- ☐ Cortisone/Steriods
- ☐ Blood Thinner
- ☐ Blood Pressure
- ☐ Hormone
- ☐ Thyroid
- ☐ Birth Control Pills
- ☐ Insulin
- ☐ Ulcer/Nexium
- ☐ Bone Related
- ☐ Antidepressants
- ☐ Cholesterol
- ☐ Pen/Amoxicillin
- ☐ Cleocin/Clindamycin
- ☐ Keflex/Cephalexin
- ☐ Z-pack

Notes: Please list **all** medications you are **currently** taking:

_____

_____

_____

_____

**Physicians Name and telephone Number:** _____

**The information above is correct.** _____ _____

Signature Date