Name:____ **Date of Birth:**________________________

Phone:____________________ **Cell:**____________________ **Email:**___________________________

Update Address (if new):____

Do you have, or have you ever had any of the following? (check all that apply or check NONE): □ **NONE**

Asthma/Allergy:	**Blood Problems:**	**Heart Problems:**
☐ Asthma ☐ Hay Fever Respiratory Problems **Allergic Reactions to:** ☐ Latex ☐ Penicillin / Other Antibiotics ☐ Aspirin, Acetaminophen ☐ Codeine or other Narcotics ☐ Barbiturates, Sedatives or Sleeping Pills ☐ Sulfa Drugs ☐ Erythromycin ☐ Dental Anesthetic ☐ Reaction to Metals ☐ Other:____________________	☐ High Blood Pressure ☐ Low Blood Pressure ☐ Blood Disease ☐ Easy Bruising ☐ Hemophilia ☐ Anemia ☐ Excessive Bleeding ☐ Previous Blood Transfusion Blood Thinners **Female Patients:** ☐Y ☐N Currently nursing? ☐Y ☐N Currently pregnant? Due Date:	☐ Angina/Chest Pain ☐ Congenital Heart Defect ☐ High Cholesterol ☐ Heart Murmur ☐ Heart Disease ☐ Heart Attack ☐ Heart Valve Problem ☐ Artificial Heart Valve ☐ Heart Surgery ☐ Taking Heart Medication ☐ Pacemaker ☐ Stroke ☐ Shortness of Breath ☐ Rheumatic/Scarlet Fever A-Fib
Liver Disease: ☐ Hepatitis ☐ Liver Disorder ☐ Jaundice	**Thyroid Disease:** ☐ Thyroid Problems ☐ Hypothyroid ☐ Hyperthyroid	**Joint/Bone Problem:** Artificial Joints **Date**______ Arthritis Bisphosphonate Rheumatism Osteoporosis

Miscellaneous Health Conditions:

☐ Acid Reflux
☐ AIDS/HIV
☐ Anxiety
☐ Cancer:
Type:___________
Date:
Colitis
Depression
Diabetes
Type:_______
A1C: _________

Dizziness
Drug/Alcohol Abuse
Dry mouth
Emphysema
Epilepsy
Fainting
Frequent Headaches
Frequent Mouth Sores
Glaucoma

Herpes/other STD
Kidney Problems
Marijuana Use
Persistent Cough
Radiation
Date:_______
Treatment
Shingles
Sinus Problems
Sleep Apnea

Swollen Glands
Tuberculosis
Tumors
Tobacco Use
Type: ___________
Ulcers

☐ Other (please describe):____

☐ Hospitalization (list any within the past 5 years):____

☐ PREMED taken prior to dental appointments? Type / Reason for taking:_____________________

Physician's Name/Clinic & Phone:____

Medications: Please list all prescribed, over the counter, and herbal medications taken on a regular basis (attach list if needed):

____

____

Signature:____ Date:__________________________

Reviewed by:_____________________________ Date:___________________