Name: ____ DOB: ____________________ Sex:_____________

Family Doctor: ____

Are you allergic to any of the following (please circle)?

Aspirin	Latex	Metal	Clindamycin	Local Anesthetics
Penicillin	Codeine	Ibuprofen	Sulfa Drugs	Other:_____________________________

List all other allergies:____

List any medications that you are taking: ____

____

____

Have you ever been required to take a pre-medication before a dental appointment? **No / Yes** - If so, why?

____

Have you ever had a cardiac stent? **No / Yes** - If so, when? ___________________________________

DO YOU HAVE A HEALTH HISTORY OF: (please answer all)?

Asthma: No / Yes - **Describe last attack** ____

Anemia: No / Yes - **What type?** ____

Bleeding Disorder: No / Yes - **What type?** ____

Acid Reflux/GERD: No / Yes ____

Tuberculosis: No / Yes ____

Heart Attack: No / Yes - **When?** ________________, Heart Murmur: No / Yes, Chest Pain: No / Yes _________

Heart Disease: No / Yes, Other Heart Problems: No / Yes - **Please describe:** ________________________

Rheumatic Fever: No / Yes, Rheumatic Heart Disease: No / Yes __________________________________

Diabetes: No/Yes **-☐Type1 ☐Type2** ____

Epilepsy: No / Yes, Convulsions: No / Yes, Seizures: No / Yes ___________________________________

Stomach or Intestinal Problems: No / Yes ____

Kidney Problems: No / Yes ____

Bladder Problems: No / Yes _________________________ Prostate Problems: No / Yes ____________________

Frequent Headaches: No / Yes ____

Blood Pressure Problems: No / Yes ____

Pregnant: No / Yes - **How far along?** ____

Hepatitis: No / Yes - **If so, which type?** _________________ Liver Disease: No / Yes ______________________

AIDS/HIV Positive: No / Yes ___________________ Herpes or Human Papilloma Virus: No / Yes _____________

Thyroid Problems: No / Yes ____

Artificial Joints: No / Yes ____

Tobacco Use: No / Yes, Vape: No/ Yes - **Please specify**:_____________________________________

Alcohol Use: No / Yes - **How much?** ____

History of recreational drug use? No / Yes ____

Anxiety: No / Yes ____

Have you ever been diagnosed with cancer? No / Yes - **If so, what kind?** ______________________________

Chemotherapy or Radiation: No / Yes – **If so, how long ago?** ________________________________

Describe any medical problems not listed above: ____

List any operations that you have had: ____

____

Signature Patient/Legal Guardian ______________________________ **Date:** ____________________________