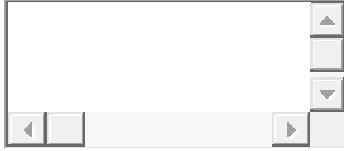


Name: _____ Date _____

Please list any medications you are currently taking, one medication per line:



Please list any vitamins/supplements you are currently taking:

Do you CURRENTLY HAVE or HAVE YOU EVER HAD any of the following? Please check (to the left of condition) all boxes that apply.

- | | | | | |
|---|---|---------------------------------|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> ALZHEIMERS | <input type="checkbox"/> Anemia | <input type="checkbox"/> HEPATITIS- A/B/C | <input type="checkbox"/> Herpes I or II |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis/Rheumatism | | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> ARTIFICIALHEARTVALVE | | | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV |
| <input type="checkbox"/> ASTHMA | | | <input type="checkbox"/> IBS/GERD | <input type="checkbox"/> Intestinal Problems |
| <input type="checkbox"/> AUTOIMMUNE DISEASE | | | <input type="checkbox"/> Jaundice/Liver probs | <input type="checkbox"/> JAW PAIN |
| <input type="checkbox"/> Back/Neck Problems | <input type="checkbox"/> BIPAP | | <input type="checkbox"/> JOINT REPLACEMENT | |
| <input type="checkbox"/> Bladder Problems | | | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> BLOOD CLOTS | <input type="checkbox"/> Blood Problems | | <input type="checkbox"/> Low Blood Pressure | |
| <input type="checkbox"/> BLOOD THINNERS | | | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Blood Transfusion | | | <input type="checkbox"/> Nursing/breastfeeding | |
| <input type="checkbox"/> Bone/Joint problems | | | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> CANCER/TUMORS | | | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> CBD/Marijuana use | | | <input type="checkbox"/> PRE MED | <input type="checkbox"/> Pregnant-currently |
| <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> Chest Pains | | <input type="checkbox"/> PULMONARY EMBOLISM | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> COVID-19 | | <input type="checkbox"/> RADIATION TREATMENT | |
| <input type="checkbox"/> C-PAP/SNORING DEVICE | | | <input type="checkbox"/> RESPIRATORY PROBLEMS | |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> DEMENTIA | | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> DIABETES: Type? | | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Disabled | <input type="checkbox"/> Drug/Alcohol Abuse | | <input type="checkbox"/> SJOGRENS Syndrome | |
| <input type="checkbox"/> Dry Mouth=Xerostomia | | | <input type="checkbox"/> SLEEP APNEA | |
| <input type="checkbox"/> Epilepsy | | | <input type="checkbox"/> SMOKE/VAPE/CHEW | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gout | <input type="checkbox"/> STD(s) - type | <input type="checkbox"/> STROKE/TIA |
| <input type="checkbox"/> Headache-freq/severe | <input type="checkbox"/> Hearing Loss | | <input type="checkbox"/> SURGERY | <input type="checkbox"/> Thyroid Issues |
| <input type="checkbox"/> HEART DISEASE | | | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Tremors |
| | | | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Vertigo |

If you answered yes to any of the above questions, please explain:

Have you had any surgeries or hospitalizations? Please explain:

Are you currently under a physician's direction to PRE-MEDICATE with ANTIBIOTICS prior to dental procedures? *

Yes No

Please select an option from the list

Are you allergic or have you had an adverse reaction to any of the following: *

- | | | |
|--|---|--|
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Asprin | <input type="checkbox"/> Other antibiotics |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Other Narcotics |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Codeine <input type="checkbox"/> Demerol | <input type="checkbox"/> None |
| <input type="checkbox"/> Sedatives | <input type="checkbox"/> Metals <input type="checkbox"/> Latex | |
| <input type="checkbox"/> Sleeping Pills | <input type="checkbox"/> Rubber | |

Please select at least one option from the list

Please list any other ALLERGIES or REACTIONS you have that are not listed:

If there is anything not listed on this form that we should be aware of, please explain:

Name and phone number of your Primary Care Physician

Signature Date