Pineview Prescott Dental, LLC 680 Gail Gardner Way Prescott, AZ 86305 (928)445-9233
www.pineviewfamilydental.com pineviewfamilydental@gmail.com

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.**

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

Local Anesthetics Penicillin
Sulfa Drugs
Barbiturates
Sedatives
Sleeping Pills
Asprin
Acetaminophen
Ibuprofen
Codeine Demerol
Metals Latex
Rubber
Other antibiotics
Other Narcotics
OTHER
None

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