Patient Name: _____

Date of Birth: _____ Male _____ Female_____

If female please check any that apply:

- ☐ Taking Birth Control
- ☐ Pregnant If yes, # of weeks_____
- ☐ Breastfeeding

Habits:

- ☐ Smoker (cigarettes, cigars, other)
- ☐ Chewing tobacco
- ☐ Other: _____

Please List ALL Medications you are currently taking (Including vitamins, supplements and over the counter medications):

_____ _____

_____ _____

_____ _____

_____ _____

Indicate which of the following you currently have or have had. Check box to indicate yes.

☐	Angina Pectoris	☐	Epilepsy	☐	Hepatitis C	☐	Artificial Joint
☐	Artificial Heart Valve	☐	Seizures	☐	HIV +/ AIDS	☐	Sexually Transmitted Disease (Venereal Disease)
☐	Congenital Heart Defect	☐	Fainting Spells	☐	Shingles	☐	Bisphosphonates (Fosamax, Boniva, Actonel, Etc.)
☐	Mitral Valve Prolapse	☐	Frequent Headaches	☐	Psychiatric Problems	☐	Depression
☐	Pace Maker	☐	Cancer	☐	Rheumatic Fever	☐	**Allergies:**
☐	Heart Attack	☐	Chemotherapy	☐	Emphysema	☐	Aspirin
☐	Heart Surgery	☐	Radiation	☐	Tuberculosis	☐	Codeine
☐	High Blood Pressure	☐	Arthritis	☐	Asthma	☐	Dental Anesthetics
☐	Low Blood Pressure	☐	Diabetes	☐	Hay Fever	☐	Erythromycin
☐	Blood Transfusion	☐	Liver Disease	☐	Sinus Problems	☐	Jewelry
☐	Abnormal Bleeding	☐	Yellow Jaundice	☐	Seasonal Allergies	☐	Latex
☐	Anemia	☐	Kidney Problems	☐	Alcohol Abuse	☐	Metals
☐	Hemophilia	☐	Thyroid Problems	☐	Drug Abuse	☐	Penicillin
☐	Sickle Cell Disease	☐	Colitis	☐	Glaucoma	☐	Tetracycline
☐	Stroke	☐	Hepatitis A	☐	Ulcers	☐	Sulfa
☐	Shunt	☐	Hepatitis B	☐	Fever Blisters	☐	Other:

Notes/Other: _____

_____

I understand this information is necessary to provide me with safe dental care and have answered all questions to the best of my knowledge.

Patient/Responsible Party Signature: _____Date_____

Doctor Signature: _____Date_____