Do you have any of the following Allergies?

Do you have any of the following allergies?

Anesthesia *

Yes No

Penicillin / Other antibiotics *

Yes No

Aspirin *

Yes No

Nsaids *

Yes No

Codeine / Other narcotics *

Yes No

Add unlisted Allergies here/type of reaction

Do you have any of the following Cardiopulmonary / blood?

Do you have any of the following cardiopulmonary / blood issues?

A-Fib *

Yes No

Emphysema / Bronchitis / Persistent cough *

Yes No

Anemia *

Yes No

Heart Problems *

Yes No

Artificial Heart Valves *

Yes No

High / Low blood pressure *

Yes No

Asthma / Breathing problems *

Yes No

Congenital Heart Lesions *

Yes No

Blood disease / Excessive bleeding *

Yes No

Pacemaker *

Yes No

Add unlisted Cardiopulmonary / Blood here

Do you have any of the following Eye, ear, nose & throat?

Do you have any of the following eye, ear, nose & throat issues?

Glaucoma *

Yes No

Sinus trouble *

Yes No

Add unlisted Eye, Ear, Nose & Throat here

Do you have any of the following gastrointestinal / urologic issues?

Do you have any of the following gastrointestinal / urologic issues?

Gastroesophageal Reflux Disease (GERD) *

○ Yes ○ No

Hepatitis / Jaundice / Liver disease *

○ Yes ○ No

Kidney problems *

○ Yes ○ No

Add unlisted Gastrointestinal / Urologic here

Do you have any of the following infectious diseases?

Do you have any of the following infectious diseases?

Herpes / Fever blisters *

○ Yes ○ No

HIV + / AIDS *

○ Yes ○ No

Add unlisted Infectious Disease here

Do you have any of the following musculoskeletal issues?

Do you have any of the following musculoskeletal issues?

Arthritis / Pain in joints *

○ Yes ○ No

Osteoporosis *

○ Yes ○ No

Artificial joints / Implants *

○ Yes ○ No

Add unlisted Musculoskeletal here

Do you have any of the following neurologic issues?

Do you have any of the following neurologic issues?

Dizziness / Fainting *

○ Yes ○ No

Frequent / Severe headaches *

○ Yes ○ No

Epilepsy / Seizures *

○ Yes ○ No

Stroke *

○ Yes ○ No

Do you have any of the following other issues?

Do you have any of the following other issues?

Tumor / Cancer / Chemotherapy / Radiation *

○ Yes ○ No

Psychiatric Care *

○ Yes ○ No

Diabetes *

○ Yes ○ No

Thyroid problems *

○ Yes ○ No

Add unlisted Other here

Additional Questions

Additional Questions

Do you take any prescriptions? *

○ Yes ○ No

Date of last dental exam

Date of last physical

Have you had any serious illness, operation, or hospitalization in the past 5 years? *

○ Yes ○ No

Are you under the care of a physician? *

○ Yes ○ No

Are you on a special diet? *

○ Yes ○ No

Have you had any head or neck injuries? *

○ Yes ○ No

Do you smoke or chew tobacco? *

○ Yes ○ No

Patient's First Name *

Patient's Last Name *

Signature *

Date *