Patient Name:	Patient DOB:	Date:

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
☐	☐	High Blood Pressure	☐	☐	Atrial Fibrillation	☐	☐	Hepatitis C
☐	☐	Low Blood Pressure	☐	☐	Abnormal Bleeding	☐	☐	Fever Blisters/ Cold Sores
☐	☐	Heart Attack	☐	☐	Taking Blood Thinners	☐	☐	STI/STD/HPV
☐	☐	Heart Surgery	☐	☐	Anemia	☐	☐	HIV+/AIDS
☐	☐	Artificial Heart Valve/Stent	☐	☐	Blood Disorder	☐	☐	Alcohol Abuse
☐	☐	Mitral Valve Prolapse	☐	☐	Blood Transfusion	☐	☐	Drug Abuse
☐	☐	Congenital Heart Defect	☐	☐	Sickle Cell Disease	☐	☐	Psychiatric Condition
☐	☐	H/O Inefective Endocarditis	☐	☐	Autoimmune Disorder	☐	☐	Allergies/Sinus Problems
☐	☐	Osteoporosis/Osteopenia	☐	☐	Kidney Disease	☐	☐	Epilepsy/Siezures
☐	☐	History of Bisphosphonates	☐	☐	Liver Disease	☐	☐	Fainting Spells
☐	☐	Arthritis	☐	☐	Asthma	☐	☐	Frequent Headaches
☐	☐	Joint Replacements	☐	☐	Emphysema/COPD	☐	☐	Glaucoma
☐	☐	Pre-medication Required	☐	☐	Sleep Apnea/Snoring	☐	☐	Rheumatic Fever
☐	☐	History of Cancer	☐	☐	Acid Reflux/GERD	☐	☐	History of Shingles
☐	☐	Chemo/Radiation Therapy	☐	☐	Colitis/IBS	☐	☐	History of Tuberculosis
☐	☐	Diabetes (Pre, Type I or II)	☐	☐	Thyroid Problems	☐	☐	Dry Mouth/Sjogrens
☐	☐	Stroke	☐	☐	Hepatitis B	☐	☐	Do you smoke or use tobacco

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other _____

_____

Y	N	Female Patient
☐	☐	Taking Birth Control Pills
☐	☐	Are you pregnant

If yes, # of weeks _____

☐ ☐ Are you nursing

Medications:

Prescription	Over-the-counter

Is there any other disease, condition, or problem that the office should be aware of?

☐ No ☐ Yes, please describe below

Signature:

Relationship to Patient:

Please complete entire form, including name and date of birth at the top, answer all questions yes or no, and sign at the bottom. Thank you