Patient Name:	Patient DOB:	Date:
Y N Conditions	**Y N Conditions**	**Y N Conditions**
☐ ☐ Abnormal Bleeding	☐ ☐ Emphysema	☐ ☐ Mitral Valve Prolapse
☐ ☐ Alcohol Abuse	☐ ☐ Epilepsy	☐ ☐ Pace Maker
☐ ☐ Allergies	☐ ☐ Fainting Spells	☐ ☐ Pneumocystitis
☐ ☐ Anemia	☐ ☐ Fever Blisters	☐ ☐ Psychiatric Problems
☐ ☐ Angina Pectoris	☐ ☐ Frequent Headaches	☐ ☐ Radiation Therapy
☐ ☐ Arthritis	☐ ☐ Glaucoma	☐ ☐ Rheumatic Fever
☐ ☐ Artificial Bones	☐ ☐ Hay Fever	☐ ☐ Seizures
☐ ☐ Artificial Heart Valve	☐ ☐ Heart Attack	☐ ☐ Shingles
☐ ☐ Asthma	☐ ☐ Heart Surgery	☐ ☐ Sickle Cell Disease
☐ ☐ Blood Transfusion	☐ ☐ Hemophilia	☐ ☐ Sinus Problems
☐ ☐ Cancer - Chemotherapy	☐ ☐ Hepatitis A	☐ ☐ Stroke
☐ ☐ Colitis	☐ ☐ Hepatitis B	☐ ☐ Thyroid Problems
☐ ☐ Congenital Heart Defect	☐ ☐ High Blood Pressure	☐ ☐ Tuberculosis
☐ ☐ Cosmetic Surgery	☐ ☐ HIV+ AIDS	☐ ☐ Ulcers
☐ ☐ Diabetes	☐ ☐ Kidney Problems	☐ ☐ Venereal Disease
☐ ☐ Difficulty Breathing	☐ ☐ Liver Disease	☐ ☐ Yellow Jaundice
☐ ☐ Drug Abuse	☐ ☐ Low Blood Pressure	☐ ☐ Do you smoke or use tobacco

Y N Allergies	**Medications:**	
☐ ☐ Aspirin	Prescription	Over-the-counter
☐ ☐ Codeine		
☐ ☐ Dental Anesthetics		
☐ ☐ Erythromycin		
☐ ☐ Jewelry		
☐ ☐ Latex		
☐ ☐ Metals		
☐ ☐ Penicillin		
☐ ☐ Tetracycline		
Other _____	Is there any other disease, condition,	
_____	or problem that the office should be	
	aware of?	☐ No ☐ Yes, please describe below
Y N Female Patient		
☐ ☐ Taking Birth Control Pills		
☐ ☐ Are you pregnant		
If yes, # of weeks _____		
☐ ☐ Are you nursing	Signature:	
	Relationship to Patient:	