Name: _____ **Date of Birth:** _____

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Alzheimers/Dementia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Bishphonates-(Fosomax, Boniva)
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Chronic Mouth Sores
☐	☐	Chronic Tiredness
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Difficulty Swallowing
☐	☐	Digestive Issues
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Fever Blisters

Y	N	Conditions
☐	☐	Frequent Headaches
☐	☐	Frequent Use Of Antacids
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Human Papilloma Virus (HPV)
☐	☐	Hypothyroid Or Hyperthyroid
☐	☐	Joint Replacement
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pain Or Difficulty Chewing
☐	☐	Pneumocystitis
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures

Y	N	Conditions
☐	☐	Sjogren's Syndrome
☐	☐	Sleep Apnea
☐	☐	Snoring
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Ulcers

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

Other

_____

_____

_____

Do you smoke or use tobacco products? Y/N

Females: Are you Pregnant? Y/N How Many Weeks? ____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below..**
