Patient Name: _____

HEALTH INFORMATION

Have you ever had any of the following medical conditions, or procedures? Please check those that apply:

- ☐ **AIDS/HIV positive**
- ☐ **Arthritis**
- ☐ **Anemia**
- ☐ **Artificial Joints**
- ☐ **Artificial Heart Valve**
- ☐ **Asthma**
- ☐ **Bronchitis / Chronic cough**
- ☐ **Cancer**
  - ☐Chemotherapy
  - ☐Radiation Therapy
- ☐ **Chemical Dependency**
- ☐ **Circulatory Problems**
- ☐ **Cortisone Treatments**
- ☐ **Diabetes**
- ☐ **Dizziness**
- ☐ **Epilepsy / Convulsions**
- ☐ **Excessive Bleeding**
- ☐ **Fainting**
- ☐ **Glaucoma / Eye disease**
- ☐ **Hay Fever / Sinus Problems**
- ☐ **Headaches**
- ☐ **Heart Conditions:**
  - ☐**Heart Disease**
  - ☐**Heart Attack(s)**
  - ☐**Irregular heart beat**
  - ☐**Chest Pain/Angina**
  - ☐**High Blood Pressure**
  - ☐**Low Blood Pressure**
  - ☐**High Cholesterol**
  - ☐**Heart Murmur**
  - ☐**Mitral valve prolapse**
  - ☐**Heart surgery**
  - ☐**Cardiac pacemaker**
- ☐ **Herpes**
- ☐ **Hepatitis**
- ☐ **Immune System problems**
- ☐ **Jaw Pain**
- ☐ **Kidney Disease**
- ☐ **Liver Disease / Jaundice**
- ☐ **Malignant Hyperthermia**
- ☐ **Mental Health Problems**
- ☐ **Osteoporosis / Osteopenia**
- ☐ **Psychiatric Care**
- ☐ **Respiratory Treatment**
- ☐ **Rheumatic Fever**
- ☐ **Sexually Transmitted Disease**
- ☐ **Shingles**
- ☐ **Shortness of breath**
- ☐ **Snoring / Sleep Apnea**
- ☐ **Stroke**
- ☐ **Swelling of feet/ankles**
- ☐ **Thyroid disease**
- ☐ **Tobacco habit:**
  - ☐Smoking
  - ☐Smokeless
- ☐ **Tuberculosis**
- ☐ **Tumors or Growths**
- ☐ **Ulcers**
- ☐ **Other:** _____
- ☐ **Other:** _____

MEDICATION & ALLERGIES

Are you now taking or have you ever taken:

- ☐ **Antidepressants**
- ☐ **Bisphosphonates (bone density medication)**
- ☐ **Blood Thinners (Coumadin, Aspirin, Advil)**
- ☐ **Diet Pills**
- ☐ **Insulin**
- ☐ **Muscle relaxers**
- ☐ **Nerve pills**
- ☐ **Pain killers (including aspirin)**
- ☐ **Stimulants**
- ☐ **Tranquilizers**

Please list any other medication(s) you are taking (including over the counter, herbal or homeopathic products):

_____

Are you allergic to or have you ever had a reaction to:

- ☐ **Penicillin**
- ☐ **Amoxicillin**
- ☐ **Sulfa Drugs**
- ☐ **Sulfites**
- ☐ **Codeine or other narcotics**
- ☐ **Local Anesthetic (numbing med)**
- ☐ **Aspirin**
- ☐ **Valium**
- ☐ **Latex products**
- ☐ **Other:** _____
- ☐ **Other:** _____
- ☐ **Other:** _____

1-4 below for women only: (women note: antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control)

1. Is there a possibility of pregnancy? ☐ Yes ☐ No

2. Expected delivery date: _____

3. Are you nursing? ☐ Yes ☐ No

4. Are you taking birth control pills? ☐ Yes ☐ No

Signature of patient, parent or guardian _____ Date _____