Patient's name_____ Date of birth _____
Medical Doctor_____
Medical Doctor's address and phone number_____
_____
Are you currently under a physician's care? ☐ yes ☐ no
Why?_____
List all medications you are taking (either prescribed by a physician or over the counter)
_____
_____
_____
_____
_____
Have you ever had any allergic reaction to any antibiotics or medications? ☐ yes ☐ no
_____
Have you ever had any allergic reaction to any anesthetics or dental materials? ☐ yes ☐ no
_____

Please check all that apply:

___ Pregnant or suspect you might be
___ Nursing
___ Take birth control medications
___ Heart disease
___ Heart murmurs
___ Mitral valve prolapse
___ Pacemaker or artificial heart valve
___ Rheumatic fever
___ High blood pressure
___ Low blood pressure
___ Anemia
___ Leukemia
___ Any other blood disorder
___ Radiation and/or chemo treatment
___ Serious illness or major surgery
_____
___ Artificial joints or prosthesis
_____
___ Bled excessively after being cut/injured

___ Stomach problems
___ Kidney problems
___ Liver problems
___ Diabetic
___ Asthma
___ Epilepsy or seizures
___ HIV positive
___ AIDS
___ Hepatitis / Which type? _____
___ Tuberculosis
___ Smoke tobacco
___ Chew tobacco
___ Consume alcohol
___ Psychiatric treatment
___ Use controlled substances

Do you have any disease, condition, or problem not listed? If so,
explain?_____
Would you like to speak to the doctor privately about any problem?_____
_____

Patient's signature_____ Date_____

Dentist's signature _____ Date _____