

NAME _____

DATE _____

DO YOU REQUIRE PREMEDICATION WITH ANTIBIOTICS PRIOR TO DENTAL TREATMENT? Y N

ANTIBIOTIC PRESCRIBED: _____

ALLERGIES (list all, including medications): _____

Are you currently under a doctor's care? Y N

Reason: _____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (circle Yes or No)

- | | | |
|---------------------------------|--------------------------------|-----------------------------|
| Y N Mitral Valve Prolapse | Y N Asthma/Hay fever | Y N Latex Allergy |
| Y N Pacemaker | Y N Arthritis | Y N Major Operation/Surgery |
| Y N Heart Trouble | Y N Bleeding (excessive) | Y N Serious Accident |
| Y N Heart Murmur | Y N Blood Pressure H/L ↑ ↓ | Y N Soda Consumption |
| Y N Heart Valve Replacement | Y N Blood Transfusion | # of 8oz. per day: _____ |
| Y N Joint Replacement | Y N Chemo or Radiation Therapy | Y N Stroke |
| Y N Hip/Knee R/L Date: _____ | Y N Diabetes | Y N Thyroid |
| Y N Allergies | Y N Epilepsy/Seizures | Y N Tobacco Use |
| Y N Rheumatic Fever | Y N Fainting/Dizziness | Y N Trauma to Face/Jaw |
| Y N Acid Reflux | Y N Fibromyalgia | Y N Tuberculosis |
| Y N ADD or ADHD | Y N Headaches/Migraines | Y N Tumor/Cancer |
| Y N Alcohol/Chemical Dependency | Y N Heart Attack | Y N Pregnant |
| Y N Anemia | Y N Hepatitis | Due Date: _____ |
| Y N Anorexia/Bulimia | Y N HIV/AIDS/Herpes II | |
| Y N Anxiety/Depression | Y N Kidney Problems | |

Any other health conditions not mentioned above? _____

NOTES: _____

LIST ALL MEDICATIONS YOU ARE TAKING AND REASONS (including Aspirin):

- | | |
|---------------|---------------|
| TAKING: _____ | REASON: _____ |
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| TAKING: _____ | REASON: _____ |
| TAKING: _____ | REASON: _____ |

SIGNED: _____

(PARENT/Guardian if patient is a minor)

DATE: _____