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 **Y**es or **N**o)

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: _____
TAKING: _____	REASON: _____
TAKING: _____	REASON: _____
TAKING: _____	REASON: _____
TAKING: _____	REASON: _____
TAKING: _____	REASON: _____
TAKING: _____	REASON: _____
TAKING: _____	REASON: _____
TAKING: _____	REASON: _____
TAKING: _____	REASON: _____

SIGNED: _____ DATE: _____
PATIENT or (PARENT/Guardian if patient is a minor)