MEDICATIONS

List any medications you are currently taking:

____

____

____

Pharmacy ____________________ Phone __________

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other (please list) ____________________

____

____

DENTAL

What problems, if any, are you having with your teeth?

____

What bothers you, if anything, about your teeth i.e. color, shape, spaces, crowding, etc?

____

Are there any dental conditions of which we should be aware i.e. bleeding gums, dental trauma, etc?

____

How many times a day do you brush your teeth? __________

What type of bristles do you use? __________

How many times a week do you floss? __________

Women:

are you pregnant? yes or no if yes, # of months; __________

are you nursing? yes or no

are you currently on birth control? yes or no

CHECK ANY SYMPTOM(S) OR CONDITION(S) BELOW THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST

- ☐ AIDS
- ☐ Appendicitis
- ☐ Angina
- ☐ Arm Pain or Numbness
- ☐ Arthritis
- ☐ Artificial Joint Replacement
- ☐ Asthma
- ☐ Back Pain or Numbness
- ☐ Bleeding Disorders
- ☐ Blood in Urine
- ☐ Blurred Vision
- ☐ Bruise Easily
- ☐ Bursitis
- ☐ Cancer- type __________
- ☐ Cardiac Pacemaker
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Constipation
- ☐ Coronary Disease
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Depression/Nervousness
- ☐ Difficulty Swallowing
- ☐ Dizziness/Fainting
- ☐ Double Vision
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Ear ache
- ☐ Foot Pain or Numbness
- ☐ Fever
- ☐ Frequent Urination
- ☐ Glaucoma
- ☐ Hand Pain or Numbness
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Heart Valve Replacement
- ☐ Hemorrhoids
- ☐ Hepatitis _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hip Pain or Numbness
- ☐ HIV Positive
- ☐ Hives
- ☐ Indigestion
- ☐ Irregular Heartburn
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Lack of Bladder Control
- ☐ Leg Pain or Numbness
- ☐ Liver Disease
- ☐ Loss of Hearing
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Low Blood Pressure
- ☐ Measles
- ☐ Mitral Valve Prolapse
- ☐ Migraine Headaches
- ☐ Nausea
- ☐ Neck Pain or Numbness
- ☐ Neuralgia
- ☐ Neurologicial Disease
- ☐ Nose Bleeds
- ☐ Persistent Cough
- ☐ Pneumonia
- ☐ Polio
- ☐ Poor Appetite
- ☐ Poor Circulation
- ☐ Prostate Problem
- ☐ Rapid Heartbeat
- ☐ Rash
- ☐ Rectal Bleeding
- ☐ Rheumatic Fever
- ☐ Ringing in Ears
- ☐ Scarlet Fever
- ☐ Sexual Transmitted Disease
- ☐ Shoulder Pain or Numbness
- ☐ Sinus Problems
- ☐ Sore Throat Won't Heal
- ☐ Stomach Aches or Pains
- ☐ Stomach Ulcer/Hyperacidity
- ☐ Stroke
- ☐ Swelling Ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Vomitting
- ☐ Vomitting Blood

If you have any disease or medical condition not listed above, please explain ______________________________

____

If you have had any surgery or treatment for any condition listed above, please list procedure and dates: ______________________________

____

Do you smoke or use tobacco in any form? yes or no

Do you drink more than two alcoholic beverages per day? yes or no

Signature ______________________________ **Date** __________