

Patient Name: _____

Date of Birth: _____

Are you taking any drugs or medications?

Yes No

If so, please list them: _____

Do you have any drug **ALLERGIES** (including latex or rubber)?

Yes No

Penicillin Erythromycin Keflex or Suprax Sulfa Codeine Novocaine or other anesthetic

Aspirin Latex Other: _____

Have you ever been told by a physician you need **PREMED** antibiotics before dental treatment? Yes No

Have you ever been told that you should not donate blood? Yes No

Do you use tobacco in any form (smoking, chewing)? Yes No

Females: Are you taking birth control pills? Yes No

Are you or might you be pregnant? Yes No

Are you breast feeding at the present time? Yes No

Have you ever had or have now:

Blood Disease or
Bleeding disorders

Rheumatic Fever/Mitral
Valve Prolapse

Hepatitis, type if
known _____

Heart disease/surgery
/problems

TB (Tuberculosis) or
PPD positive

Heart Murmur, type if
known: _____

High Blood Pressure

Sinus Problems

Emphysema (COPD)

Thyroid disorder

Cold sores (herpes)

AIDS or HIV positive

Joint Replacement

Epilepsy or seizures

Venereal Disease

Artificial Heart Valve

Cancer/radiation therapy

Stroke

Pacemaker

Diabetes

Kidney disorder

Ulcers

Arthritis

Alcoholism

Hay fever

Asthma

Chemical dependence

Any other medical concerns not listed above? _____

Patient's/Guardian's signature

Date