

Patient's Name _____
LAST FIRST M

1. List reason(s) for which you are seeking care _____

2. Next of Kin / Emergency Contact _____ (_____) _____
NAME RELATIONSHIP TO PATIENT DAY TIME PHONE INCLUDING AREA CODE

3. Have you **EVER** been a patient in any hospital/out patient surgery facility? YES NO

LIST ALL hospitalizations since childhood on the **REVERSE SIDE**.

4. Are you under the care of a medical doctor for a specific problem? YES NO

If YES, name of family doctor, specialist and reason for treatment can be completed on the **REVERSE SIDE**.

5. When did you last visit a physician? _____ Why? _____

6. Are you taking any medicine or drugs daily including over the counter medications, such as aspirin or Motrin? YES NO

If YES, please list drug, frequency, and dosage on the **REVERSE SIDE** (to avoid bleeding problems)

7. Have you ever had an allergic reaction to any drugs / medications / latex? YES NO (i.e., itching, rash, swelling of hands, feet, or eyes)

Penicillin Aspirin Codeine Latex Other _____ Type of Reaction: _____

8. Have you ever had any excessive bleeding, YES NO

Or take Blood Thinners like Coumadin Aspirin NSAIDS Anti-platelet medicines

9. Have you ever had or do you currently have:

- | | | |
|---|---|---|
| Emphysema <input type="checkbox"/> YES <input type="checkbox"/> NO | Osteoporosis..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Disease or Attack <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Tuberculosis (TB)..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Hepatitis A (infectious)..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Angina Chest Pain <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Asthma..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Hepatitis B (serum)..... <input type="checkbox"/> YES <input type="checkbox"/> NO | High Blood Pressure <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hay Fever..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Blood Transfusion <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Murmur..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sinus Trouble..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Drug Addiction - Alcohol Abuse ... <input type="checkbox"/> YES <input type="checkbox"/> NO | Rheumatic Fever..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Allergies or Hives <input type="checkbox"/> YES <input type="checkbox"/> NO | Artificial Heart Valve <input type="checkbox"/> YES <input type="checkbox"/> NO | Congenital Heart Disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Pacemaker <input type="checkbox"/> YES <input type="checkbox"/> NO | Thyroid Disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Oral or Genital Herpes <input type="checkbox"/> YES <input type="checkbox"/> NO | Arthritis..... <input type="checkbox"/> YES <input type="checkbox"/> NO | X-ray/Cobalt/Chemotherapy .. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial Joint..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Stroke..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Cancer/Tumors..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cortisone Medicine <input type="checkbox"/> YES <input type="checkbox"/> NO | Kidney Trouble..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Epilepsy or Seizures..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Psychiatric Treatment..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Stomach Ulcers..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Glaucoma <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sickle Cell Disease..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Sleep Apnea..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Oral Yeast Infection <input type="checkbox"/> YES <input type="checkbox"/> NO |

10. Do you have any other medical condition that you wish to discuss privately with the doctor? YES NO

11. When you walk upstairs or take a walk, do you have to stop because you have pain in your chest, are short of breath, or are very tired?..... YES NO

12. Do you smoke?..... YES NO No. of years, _____ Packs / Day _____?

13. Do you drink alcoholic beverages?..... YES NO How often? _____

14. Have you ever had a jaw joint (TMJ) problem YES NO

(clicking, locking, headaches)? If YES, explain on the **reverse side**.

15. Have you or any family member had any problems with anesthesia? YES NO

16. WOMEN: Are you pregnant?..... YES NO

(NOTE: If you receive a prescription, it may affect medication taken for birth control. Use other methods of birth control if applicable.)

17. Are you NOW taking or have you EVER taken bisphosphonate drugs (i.e. Fosamax, Actonel or others) for osteoporosis or bone cancer treatment?..... YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health, or if my medicines change, I will inform the doctor at the next appointment.

 Date

 Signature of Patient, Parent, or Legal Guardian

PATIENT'S COMMENTS

Number 3: Hospitalizations from CHILDHOOD TO PRESENT including anesthesia procedures (when, where, for what)

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Number 4: Family Doctor (name, location, reason for treatment)

Specialist (Heart, Kidney etc.)

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Number 6: Medications/Drugs, Herbals, Over the Counter (name, frequency, dosage) / or provide a list.

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Number 14: TMJ Symptoms

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Thank you!
We look forward to serving you!