



Patient Name : _____
Date of Birth : _____
Today's Date: _____

Medical History

Do you have any of the following **medical conditions**? Please check all that apply

- Heart Disease Hypertension Stroke Cancer Asthma Diabetes
- Psoriasis Migraine Headaches Anxiety Disorder Seizure Disorder

Please List any additional medical conditions: _____

Are you taking any of the following **medications**? Please check all that apply

- Minocycline Aspirin Plavix Coumadin Prednisone Requip
- Valium Xanax Ativan Pain Medications Lopressor

Please List any additional medications: _____

Are you taking Estrogen/Progesterone/Birth Control Pills now?..... Yes No

Are you allergic to **Latex**..... **Sulfa** or **Local Anesthetics**?
Are you allergic to **any other Medications**? _____

Do you require antibiotics before surgery or dental work?..... Yes No

Please List any **Surgeries** you have had _____

Are you currently pregnant, trying to get pregnant, or planning a pregnancy? Yes No

Do you **smoke tobacco**?.... Yes No If Yes how long _____

What kind of work do you do? _____

Who Is your **Primary Doctor** _____

Additional Notes _____

Patient Signature _____ Date _____