

Patient Name: _____
Last First MI Preferred Name

Physician Name & Phone Number: _____

If female please answer the following:

Are you taking birth control? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

Medical Alerts

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other | <input type="checkbox"/> Allergy - Aspirin |
| <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro | <input type="checkbox"/> Allergy - Hay Fever | <input type="checkbox"/> Allergy - Latex |
| <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa | <input type="checkbox"/> Allergy-Tetracycline |
| <input type="checkbox"/> Alzheimers/Dementia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Bone Loss Medication | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cold Sores/Herpes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Head/Neck Injuries | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hemophilic | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker/Stents |
| <input type="checkbox"/> Radiation/Chemo | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors/Growths | <input type="checkbox"/> Ulcers | |

Do you use tobacco products? Yes No

Medications:

ALL Past Surgeries:

Response Date: ___/___/___