

PATIENT NAME: _____

MEDICATIONS YOU ARE TAKING AND THE CORRELATING DIAGNOSIS
INCLUDE NATURAL HERBS AND VITAMINS

ARE YOU PREGNANT? _____ DUE DATE: _____ OBGYN: _____

ALLERGIES: CHECK ALL THAT APPLY

- | | |
|---|---|
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> METALS (gold, iron, tin, nickel, zinc, silver) |
| <input type="checkbox"/> LATEX | <input type="checkbox"/> PAIN RELIEVERS _____ |
| <input type="checkbox"/> SLEEPING PILLS | <input type="checkbox"/> SULFA (antibiotics) |
| <input type="checkbox"/> CODEINE | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> IODINE | |
| <input type="checkbox"/> LOCAL ANESTHETIC | |
| <input type="checkbox"/> PENICILLIN | |
| <input type="checkbox"/> IBUPROFEN | |

PLEASE MARK ANY CONDITIONS THAT WOULD APPLY TO PATIENT:

If you have a condition not listed, please list in the area marked OTHER.

- | | |
|---|--|
| <input type="checkbox"/> DOES PATIENT NEED TO BE
PREMEDICATED BEFORE DENTAL
APPOINTMENT | <input type="checkbox"/> MUSCULAR DYSTROPHY |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> NERVOUS PROBLEMS |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> ARTHRITIS, RHEUMATISM | <input type="checkbox"/> RADIATION TREATMENT |
| <input type="checkbox"/> ARTIFICIAL HEART VALVES | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> BACK PROBLEMS | <input type="checkbox"/> SEIZURES/CONVULSIONS |
| <input type="checkbox"/> BLEEDING ABNORMALLY WITH
EXTRACTIONS OR SURGERY | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> BLOOD DISEASE/BLOOD CLOTS | <input type="checkbox"/> SINUS TROUBLE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> SKIN RASH |
| <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> SPECIAL DIET |
| <input type="checkbox"/> CHOLESTEROL | <input type="checkbox"/> SWOLLEN FEET OR ANKLES |
| <input type="checkbox"/> CROHNS DISEASE | <input type="checkbox"/> SWOLLEN NECK GLANDS |
| <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> CORTISONE TREATMENTS | <input type="checkbox"/> TONSILITIS |
| <input type="checkbox"/> COUGH, PERSISTENT OR BLOODY circle | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> TUMOR OR GROWTH ON HEAD OR NECK |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> VENEREAL DISEASES (STD's) |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> WEIGHT LOSS, unexplained |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> FAINTING OR DIZZINESS | _____ |
| <input type="checkbox"/> GLAUCOMA | |
| <input type="checkbox"/> HEADACHES | |
| <input type="checkbox"/> HEART MURMUR | |
| <input type="checkbox"/> HEART PROBLEMS _____ | |
| <input type="checkbox"/> HEPATITIS TYPE _____ | |
| <input type="checkbox"/> HERPES | |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | |
| <input type="checkbox"/> JAUNDICE | |
| <input type="checkbox"/> JAW PAIN | |
| <input type="checkbox"/> KIDNEY DISEASE | |
| <input type="checkbox"/> LIVER DISEASE | |
| <input type="checkbox"/> LOW BLOOD PRESSURE | |
| <input type="checkbox"/> MITRO VALVE PROLAPSE | |
| <input type="checkbox"/> MULTIPLE SCLEROSIS | |
| <input type="checkbox"/> PARKINSON'S DISEASE | |

PATIENT SIGNATURE:
(OR ADULT/GUARDIAN IF MINOR)

DATE: _____