IF YOU ARE TAKING MEDICATION FOR ANY CONDITION, PLEASE LIST IT BELOW

PAST OR CURRENT MEDICAL CONDITIONS (check all that apply)

- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Bacterial Endocarditis
- ☐ Blood Thinner
- ☐ Chemotherapy
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Latex Allergy
- ☐ Radiation
- ☐ Stroke
- ☐ Treatment for Osteoporosis

- ☐ Acid Reflux
- ☐ AIDS/exposed to AIDS
- ☐ Allergies (please list)
- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Artificial Joint
- ☐ Artificial Valve
- ☐ Asthma
- ☐ Bacterial Endocarditis
- ☐ Blood Thinner
- ☐ Bruise Easily
- ☐ Cancer and/or Tumors
- ☐ Chemotherapy
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Drug/Alcohol Addiction
- ☐ Emphysema/COPD
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting or Dizzy Spells
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ Kidney Condition
- ☐ Latex Allergy
- ☐ Liver Condition
- ☐ Medications (please list)
- ☐ No Epinephrine
- ☐ Osteoporosis Medication
- ☐ OTHER (please list)
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Pregnant
- ☐ PREMED
- ☐ Psychiatric Treatment
- ☐ Radiation
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ STD
- ☐ Stroke
- ☐ TMJ Problems
- ☐ Tobacco Use
- ☐ Tuberculosis

PLEASE LIST YOUR MEDICATIONS:

_____

_____

ALLERGIES: PLEASE LIST

_____

_____

OTHER: PLEASE LIST

_____

_____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I HAVE ANY CHANGES IN MY HEALTH OR MEDICATIONS, I WILL INFORM THE DENTIST AT MY NEXT APPOINTMENT.

SIGNATURE: _____ **DATE:** _____