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|---|--|
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> High or Low Blood Pressure (S___/D___) | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Herpes (1) or (2) | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Implants | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Joint Replacement (Knee, Hip) | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Urinary Infections |
| <input type="checkbox"/> Pacemaker / Defibrillator | <input type="checkbox"/> Use of Cocaine (effects dental anesthetic) |
| <input type="checkbox"/> Pre-Medicare for Dental Treatment | <input type="checkbox"/> White patches in the Mouth |
| <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Women are you: Pregnant ___ Nursing ___ Birth Control Pills ___ HRT ___ ? |

MEDICATIONS

List prescription medications you are currently taking:

Pharmacy Name: _____

Pharmacy Phone: _____

List over the counter medicines you are taking: _____

ALLERGIES

- Aspirin
- Barbiturates (Sleeping Pills)
- Codeine
- Metals
- Sulfa
- Latex
- Local Anesthetic
- Penicillin
- Pollen
- Jewelry
- Other _____

What family member may we share this information with?

Name _____ Relationship _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: _____