1. Reason for today's visit: _____

2. Are you now or have you been under a medical doctor's care during the past two years?: Yes ☐ No ☐

   For what reason(s)?: _____

   When was the last appointment(s)?: _____

   Name of all medical doctors: _____

3. Have you taken any kind of medication or drugs during the past year?: Yes ☐ No ☐

   What medication(s)?: _____

4. Are you taking any medications now , including diet medication?: Yes ☐ No ☐

   List medication(s): _____

5. Are you now or have you ever taken steroids?: (Example: Cortisone) Yes ☐ No ☐

   What steroid medication(s)?: _____

6. Allergies to any medications or latex rubber?: Yes ☐ No ☐

   List allergies: _____

7. Do you bleed excessively after a cut, wound, surgery or tooth extraction and were you ever hospitalized for the bleeding ?: Ye s ☐ No ☐

8. Do you take daily aspirin or blood thinners?: Yes ☐ No ☐

   What aspirin or blood thinner?: _____

9. Have you ever had any breathing difficulty, chronic cough, bronchitis, emphysema, pneumonia, TB, or other lung disorder?: Yes ☐ No ☐

   When and what treatment?: _____

10. Have you ever been exposed to TB?: Yes ☐ No ☐

    When and what treatment?: _____

11. Do you smoke?: Yes ☐ No ☐

    How much and how long?: _____

12. Do you drink alcoholic beverages?: Yes ☐ No ☐

    How much and how often?: _____

13. Check "Y" or "N" for the following medical questions:

___Y / N ___ HEART TROUBLE/IRREGULAR BEAT
___Y / N ___ CONGENITAL HEART PROBLEMS
___Y / N ___ HEART MURMUR
___Y / N ___ RHEUMATIC FEVER
___Y / N ___ HIGH BLOOD PRESSURE
___Y / N ___ STROKE
___Y / N ___ DIABETES
___Y / N ___ HISTORY DRUG/ALCOHOL ABUSE
___Y / N ___ ASTHMA (last attack) _____
___Y / N ___ RADIATION TREATMENTS
___Y / N ___ STOMACH ULCER
___Y / N ___ POOR SLEEP
___Y / N ___ ARTIFICIAL VALVE, JOINTS
___Y / N ___ IMPLANTS, SCREWS

___ Y / N ___ THYROID DISEASE
___ Y / N ___ KIDNEY DISEASE
___ Y / N ___ ANEMIA
___ Y / N ___ EPILEPSY OR SEIZURES
___ Y / N ___ PSYCHIATRIC TREATMENT
___ Y / N ___ HEPATITIS OR LIVER DISEASE
___ Y / N ___ CONTACT LENSES
___ Y / N ___ DIFFICULTY WITH ANESTHETIC
___ Y / N ___ PACEMAKER
___ Y / N ___ LOUD OR DISTURBING SNORING
___ Y / N ___ TMJ PROBLEMS
___ Y / N ___ NEED PREOPERATIVE ANTIBIOTICS
___ Y / N ___ HIV or IMMUNOSUPPRESSION DISORDERS
___ Y / N ___ AUTOIMMUNE DISORDERS

14. Are there any other diseases, medical problems or other information that were not asked above?: Yes ☐ No ☐
    Please explain: _____

15. WOMEN - Is there a possibility that you are currently pregnant?: Yes ☐ No ☐ If Yes, how many weeks? _____

16. Doctor's note: _____

    _____

17. I give authorization for the doctor to examine me as may be deemed necessary or advisable for diagnosis and treatment planning.

SIGNATURE: _____ REV'D by DR.: _____ DATE: _____