

Print Patient Name:

Date of Birth:

MEDICAL HISTORY (Please check any of the following conditions you may have.)

- | | | |
|-------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Heart Attack DATE_____ | <input type="checkbox"/> Asthma/Hay fever | <input type="checkbox"/> Anemia (low blood) |
| <input type="checkbox"/> Prolapsed Mitral Valve | <input type="checkbox"/> Sinus Trouble/Allergies | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver Disease/Hepatitis |
| <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> TMJ (Jaw Joint Problems) |
| <input type="checkbox"/> Heart Surgery DATE_____ | <input type="checkbox"/> Steroid Therapy | <input type="checkbox"/> Cancer/Tumor (Type_____) |
| <input type="checkbox"/> Prosthetic Heart Valve | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stomach Ulcers/GERD |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Fainting Spells/Seizures | <input type="checkbox"/> Drug Dependency |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Anticoagulants (Blood Thinners) | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Auto Immune Deficiency Syndrome | <input type="checkbox"/> Joint Replacement
Date_____ |
| <input type="checkbox"/> Other Heart Issues (explain) | <input type="checkbox"/> Chronic Pain (explain) | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Surgery in the past year
(Explain Reason/Date)_____ | |

Are you under the care of a physician?
 YES NO If yes, please explain.

PHYSICIAN AND PHARMACY INFORMATION

Physician Name: 

Physician Phone: ()

Preferred Pharmacy: 

Pharmacy Phone: ()

Street Address:

Do you want Nitrous Oxide? YES NO

Additional charge, not usually covered by Insurance **\$ 100**

MEDICATIONS

Are you currently taking any medications? Yes No
 Please list any current medications & supplements
 (use a separate sheet if necessary)

ALLERGIES

NO KNOWN ALLERGIES

I am allergic or have had a reaction to the following:

- | | |
|--------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Latex | <input type="checkbox"/> Other, Please List |
| <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> Codeine | _____ |
| <input type="checkbox"/> Asprin | _____ |
| <input type="checkbox"/> Sulfa Drugs | _____ |

FOR WOMEN ONLY

- Are you or could you be pregnant? YES NO
 Are you nursing? YES NO
 Are you taking birth control pills? YES NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform this office of any changes in medical status.

Signature of PATIENT or GUARDIAN

DATE