Patient Name: Today's Date:

Primary Care Provider: Date of Birth:

Any specific concerns you have today?

How often do you brush? How often do you floss?

How can we help make your dental visits the most comfortable?

Please mark an X in any box that applies to your medical history:

- ☐ Do you snore?
- ☐ Sleep Apnea: Do you use a CPAP? Yes No
- ☐ Heart Disease
- ☐ High or Low Blood Pressure
- ☐ Pacemaker or Heart Valve Repair
- ☐ Stroke
- ☐ Anemia/Taking a Blood Thinner/ Bleeding Disorder
- ☐ Allergies to Medications: (please circle) Aspirin, Ibuprofen, Sulfa Drugs, Penicillin, Codeine, Other _____
- ☐ Allergy to Latex, Metal, Plastic
- ☐ Lung Disease or Asthma
- ☐ Epilepsy or Seizures
- ☐ GERD/Acid Reflux
- ☐ Liver Disease or Jaundice
- ☐ Diabetes: A1C ____
- ☐ Women: pregnant or nursing
- ☐ History of Cancer, Chemotherapy or Radiation
  Cancer Type: _____
  Diagnosis Date: _____
- ☐ Drug or Alcohol Dependency
- ☐ Kidney Disease
- ☐ HIV/AIDS
- ☐ Hyperthyroidism/Hypothyroidism
- ☐ History or emotional or nervous disorders: _____
- ☐ I use Tobacco or Smoke: # packs per day: ____ # years use ____
- ☐ I usually take antibiotics prior to dental treatment
- ☐ History of Joint Replacements
  - ☐ Hip: Date _____
  - ☐ Knee: Date ____
  - ☐ Other joint: Date ____

List Medications and Supplements

_____
_____
_____
_____
_____
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_____
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_____
_____
_____