

PATIENT INFORMATION **DATE:** _____

Name: _____ Gender: M / F DOB: _____ Age: _____
 Phone #: _____ Height (ft): _____ Weight (lbs): _____ BMI (staff complete): _____

SURGICAL AND ANESTHESIA HISTORY

Have you ever had surgery before (**List below**)?Y / N
 Please list _____
 Have you ever had anesthesia before?Y / N
If yes, did you have any complications from anesthesia that you know of? (list:) _____
 Has anyone else in your family had aa problem with anesthesia? Y / N

MEDICAL HISTORY

General practitioner's name: _____ Phone #: _____ Last Visit: _____
 Do you see any other doctors/ specialty providers?.....Y / N
If yes, Who and why? _____
 Do you see any doctors for pain management?.....Y / N
If yes, Who and why? _____
 Have you ever been hospitalized for any illness?Y / N
If yes, When and Why? _____
 Have you ever been told to take an antibiotic before going to the dentist due to orthopedic or cardiac reasons?.....Y / N
If yes, Why and What? _____

ALLERGIES

List any allergies and reactions: _____
 Allergic to latex.....Y / N

MEDICATIONS AND SUPPLEMENTS (please list **ALL** medications and supplements, including doses and frequency)

None

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

BONE/OSTEOPOROSIS/WEIGHT LOSS/DIABETIC DRUGS : (check one for each question)

Are you currently taking any bone loss/osteoporosis medications?
 Fosamax Boniva Zometa Aredia Didronel Reclast Prolia Xgeva None Other _____
 When was your last injection? _____ How many injections have you had? _____

Are you currently taking any weight loss/diabetic medications?
 Ozempic Wegovy Trulicity Mounjaro Zepbound Phentermine (Adipex) None Other _____
 What day of the week do you take your injections? _____

HEART/CARDIO (Please add any diagnoses not listed)	LUNGS/RESPIRATORY (Please add any diagnoses not listed)
High blood pressure..... Y / N Heart attack / MI..... Y / N Heart disease..... Y / N Valve problems..... Y / N Valve replacement..... Y / N Pacemaker or defibrillator..... Y / N Chest pain / angina / palpitations..... Y / N Recently lost / gained weight without trying..... Y / N Shortness of breath..... Y / N Heart failure..... Y / N Rheumatic Fever..... Y / N Heart infection / endocarditis..... Y / N Peripheral Vascular Disease..... Y / N Other? Please list: _____	Asthma..... Y / N Inhaler Y / N COPD..... Y / N Emphysema..... Y / N Do you snore..... Y / N Sleep Apnea...(Central or Obstructive)..... Y / N CPAP..... Y / N Chronic cough Y / N Recent cold or flu..... Y / N Recent travel out of the country..... Y / N Cigarette / cigars / smokeless / vaping Y / N How much? ____ packs per day..... How long? ____ years History of tuberculosis (TB)..... Y / N Pulmonary hypertension..... Y / N Difficulty breathing? Y / N Use oxygen at home?..... Y / N Other? Please list: _____
HEAD/NEUROLOGY/MUSCULOSKELETAL	STOMACH/BOWEL/KIDNEY/LAB VALUES
Stroke..... Y / N Seizures / Epilepsy..... Y / N Debilitating headaches/Migraines Y / N Glaucoma Y / N Fainting Y / N Parkinson's Y / N Multiple Sclerosis Y / N Muscle disorders Y / N Arthritis...(Osteoarthritis or Rheumatoid) Y / N Joint Replacement Y / N Anxiety / Depression Y / N Bipolar / Schizophrenia Y / N Dementia / Alzheimer's Y / N Other? Please list: _____	Acid reflux / heart burn / peptic ulcer disease..... Y / N Gout..... Y / N Irritable Bowel Syndrome Y / N History of C-Diff..... Y / N Diabetes Y / N Do you use insulin..... Y / N Peripheral neuropathy Y / N Thyroid problems Y / N Prescribed steroids Y / N Kidney problems..... Y / N Liver problems Y / N Other? Please list: _____
BLOOD RELATED/INFECTIOUS DISEASE	MISCELLANEOUS
Blood disorder..... Y / N Anemia Y / N Cancer..... Y / N Type: _____ Radiation/Chemo (when): _____ Sickle cell disease or trait Y / N Infectious Disease (MRSA, VRE, etc.) Y / N Hepatitis....Circle Type: A B C Y / N HIV or AIDs..... Y / N Religious beliefs that affect your decisions about blood..... Y / N Are you a blood donor..... Y / N Other? Please list: _____	Contact lenses or glasses Y / N How much alcohol per week _____ or N/A Use of recreational drugs Y / N Autoimmune disease Y / N Type: _____ Organ Transplant..... Y / N Other? Please list: _____ WOMEN Are you taking birth control / contraceptives..... Y / N Is there a chance you could be pregnant..... Y / N Are you breastfeeding Y / N Other? Please list: _____

Authorization and Release: I certify that I have read and understand the above information, and, to the best of my knowledge, all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners.

Signature: _____ Date: _____