Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please read carefully and answer to the best of your knowledge so we can provide proper care**

|  |  |  |
| --- | --- | --- |
| Are you currently under the care of a physician? (PCP-Primary Care Provider) | Yes | No |
| Please list the clinic and physician name: |  |  |
| Has there been any changes in your general health within the past year? | Yes | No |
| Have you had a serious illness, operation, or been hospitalized within the last 5 years? | Yes | No |
| If yes, what was the illness or problem? : |  |  |
| Are you taking or have you recently taken any prescriptions or over the counter medications? | Yes | No |
| If yes, please list all medications, natural/ herbal prescriptions, and/ or dietary supplements \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |
| Do you have an allergies to drugs, foods, medications or latex? | Yes | No |
| Allergy list: |  |  |
| Do you use recreational drugs? If yes, what: | Yes | No |
| Do you take narcotic prescription routinely or under a pain control contract? | Yes | No |
| Do you use Nicotine/ tobacco? (Smoking, snuff, chew, bidis, or vape?) | Yes | No |
| If yes, how interested are you in stopping?  ***Very, Somewhat, or not interested -Please circle*** |  |  |
| Have you had an orthopedic total joint (hip, knee, elbow, or finger) replacement?  ***If yes, what is the date of the replacement:*** | Yes | No |
| Have you had any complications with the replacement? | Yes | No |
| Have you been told to take an antibiotic prior to any surgery or dental treatment?  Also known as premed | Yes | No |
| Do you have Osteoporosis, if so, are you taking an anti-resorptive agent? | Yes | No |
| Rheumatoid Arthritis? | Yes | No |
| Artificial (prosthetic) heart valve? | Yes | No |
| Previous infective endocarditis? (Infection of the heart) | Yes | No |
| Congestive Heart Failure? | Yes | No |
| Cardiovascular Disease? | Yes | No |
| Damaged Heart Valves? | Yes | No |
| Arteriosclerosis (hardening of the arteries)? | Yes | No |
| Heart Attack? ***If so, when:*** | Yes | No |
| Heart Murmur? | Yes | No |
| Stroke? ***If so, when:*** | Yes | No |
| Pacemaker? | Yes | No |
| Congenital Heart Disease or Defect? ***If so, what:*** | Yes | No |
| Angina? (Chest pain) | Yes | No |
| Do you take any blood thinners/ anticoagulants? For example: Aspirin, Plavix, Eliquis | Yes | No |
| ADHD? | Yes | No |
| Autism? | Yes | No |
| Asthma or COPD? | Yes | No |
| Anemia? | Yes | No |
| Tuberculosis? ***If so, when:*** | Yes | No |
| High or Low blood pressure? ***🡨 Please circle*** | Yes | No |
| Diabetes, Type I or II ***🡨 Please circle*** | Yes | No |
| Cancer/ Chemotherapy/ Radiation Treatment? ***🡨Please circle*** | Yes | No |
| Autoimmune Disease? Example: Celiac disease, Multiple Sclerosis | Yes | No |
| Systemic Lupus Erythematosus? | Yes | No |
| Epilepsy? | Yes | No |
| Fainting spells or seizures? ***🡨 Please circle*** | Yes | No |
| Severe headaches or migraines? ***🡨 Please circle*** | Yes | No |
| Neurological Disorders? Example: Alzheimer’s/ Dementia, Parkinson’s | Yes | No |
| Mental Health Disorders? Example: Anxiety, Depression, PTSD, Bipolar | Yes | No |
| Eating Disorder? | Yes | No |
| Gastrointestinal disease, Reflux, persistent heartburn, ulcers or stomach problems? ***🡨 Please circle*** | Yes | No |
| Kidney Disease? | Yes | No |
| Thyroid problems? | Yes | No |
| Persistent swollen glands in the neck? | Yes | No |
| Hepatitis, Jaundice or Liver disease? ***🡨Please circle*** | Yes | No |
| HIV/ AIDS? | Yes | No |
| Sexually Transmitted disease? | Yes | No |
| Sinus troubles? | Yes | No |
| Glaucoma or cataracts? | Yes | No |
| What type of water do you drink? City, Well, Bottled, or Filtered? ***🡨 Please circle*** |  |  |
| Do you take fluoride supplements? | Yes | No |
| Do you use fluoride toothpaste? | Yes | No |
| Do you have any disease, condition or problem not listed above? Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No |
|  |  |  |
| Pregnant? If so, how many weeks? | Yes | No |
| Due Date: |  |  |
| Taking birth control or hormonal replacement? | Yes | No |
| Nursing? | Yes | No |

Patient/ Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_