



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? <i>If so, when:</i>	Yes	No
High or Low blood pressure? <i>← Please circle</i>	Yes	No
Diabetes, Type I or II <i>← Please circle</i>	Yes	No
Cancer/ Chemotherapy/ Radiation Treatment? <i>← Please circle</i>	Yes	No
Autoimmune Disease? Example: Celiac disease, Multiple Sclerosis	Yes	No
Systemic Lupus Erythematosus?	Yes	No
Epilepsy?	Yes	No
Fainting spells or seizures? <i>← Please circle</i>	Yes	No
Severe headaches or migraines? <i>← Please circle</i>	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? <i>← Please circle</i>	Yes	No
Kidney Disease?	Yes	No
Thyroid problems?	Yes	No
Persistent swollen glands in the neck?	Yes	No
Hepatitis, Jaundice or Liver disease? <i>← Please circle</i>	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? <i>← Please circle</i>		
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: _____