FOR OFFICE USE ONLY

MEDICAL & ALLERGY ALERTS

COMMENTS

Name

Email:

Address:

City & Zip:

Phone #:

Age: Birthdate:

Sex: Marital Status:

Soc. Security #:

Spouse/Parent:

Family Physician:

Referred By:

Employer:

Address:

City & Zip:

Phone #:

Insurance Company:

Ins. Group #:

Phone #:

Emergency Contact:

Address:

City & Zip:

Phone:

TO BE ANSWERED BY PATIENT

1. Are you taking any medication or presently under a physician's care? ☐ Yes ☐ No

2. Have you ever had?

Rheumatic Fever	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Heart Trouble	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Yellow Jaundice	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Kidney or Bladder Disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma or Hay Fever	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Immune Systems Disorder (inc. AIDS, HIV, ARC)	☐ Yes	☐ No
TMJ Disorder	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Digestive Diseases	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No

3. Have you ever had severe bleeding or other complications following an extraction? ☐ Yes ☐ No

4. Are you allergic to any drugs, medicines or injections? ☐ Yes ☐ No
Please list:

5. Have you ever been on cortisone or steroid therapy? ☐ Yes ☐ No

6. Have you been hospitalized in the past 5 years? ☐ Yes ☐ No

7. Are you pregnant? ☐ Yes ☐ No

8. Are you taking birth control pills? ☐ Yes ☐ No

9.Please list anything else in your medical history of significance:

10. List any medications you are currently taking:

Print Form