Patient Name:_____ Date of Birth:_____ Date:___/__/____

Telephone #:_____ Email:_____

Medical Doctor:_____ Telephone #:_____

Please list any Drug Allergies: _____

Please list any Medications:_____

Circle Yes or No to each category. If YES to any, please check the following conditions that apply

HEART CONCERNS: YES NO
- ☐ High Blood Pressure
- ☐ Murmur/Valve Disorder
- ☐ Mitral Valve Prolapse
- ☐ Blood Thinners
  Meds:_____
  INR:_____
- ☐ Congenital Heart Defect
  Repaired: **YES NO**
- ☐ Chest Pain/Angina
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Heart Stent
- ☐ History of Endocarditis
  Pre-Med: YES NO
- ☐ Prosthetic Heart Valve
  TYPE:_____
  Pre-Med: YES NO
- ☐ Heart Surgery

LUNG CONCERNS: YES NO
- ☐ Asthma
  Last Attack:_____
- ☐ Tuberculosis
- ☐ Sleep Apnea
  CPAP: **YES NO**
- ☐ COPD

LIVER DISEASE: YES NO
- ☐ Hepatitis A/B/C/D/E/G
- ☐ Cirrhosis

KIDNEY CONCERNS: YES NO
- ☐ Dialysis
- ☐ Shunt
  Date Placed:_____
  Pre-Med: YES NO

DIGESTIVE CONCERNS: YES NO
- ☐ Acid Reflux
- ☐ Ulcers
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis

NEURO CONCERNS: YES NO
- ☐ Brain Stent
  Pre-Med: YES NO
- ☐ Stroke
- ☐ Seizures/Epilepsy

ENDOCRINE DISEASE: YES NO
- ☐ Diabetes: **INSULIN or PILL**
- ☐ Thyroid: **HYPO or Hyper**

MUSCULOSKELETAL: YES NO
- ☐ Arthritis
- ☐ Connective Tissue Disease
- ☐ Artificial Joint
  Date Placed:
  Pre-Med: YES NO
- ☐ Osteoporosis
  Bisphosphonates: **YES NO**
  Medication:_____
- ☐ Jaw Joint Pain/Dysfunction

BLOOD DISORDER: YES NO
- ☐ Prolonged Bleeding
- ☐ Anemia
- ☐ Hemophilia
- ☐ Platelet Disorder
- ☐ Sickle Cell **OR** Trait
  Pre-Med: YES NO

AUTOIMMUNE DISEASE: YES NO
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Immune Suppressants

ANESTHESIA HISTORY: YES NO
- ☐ General Anesthesia/Sedation
- ☐ Complications
- ☐ Post-op Nausea
- ☐ High Fever
- ☐ Prolonged Recovery

OTHER CONCERNS: YES NO
- ☐ Cancer
  TYPE:_____
- ☐ Chemotherapy: **PILL or DRIP**
  Pre-Med: YES NO
  Date of Completion:_____
- ☐ Radiation
  Area of Radiation:_____
  Date:_____
- ☐ Recent Steroid Use
- ☐ Pain Management
  Medication:_____
- ☐ Drug/Alcohol Addiction
- ☐ Methadone Use
- ☐ Tobacco Use: **CHEW SMOKE**
  # of yrs____ Packs/Day_____
- ☐ Psychiatric Care
- ☐ Organ Transplant
  Type:_____

FEMALES ONLY: YES NO
- ☐ Birth control
- ☐ Pregnancy
  Due Date:_____

Any health concerns that are not listed above: _____

_____

_____

_____

_____

I have read, understand, and answered the above questions. I will not hold my doctor, surgeon, or any member of his staff, responsible for any errors or omission that I have made in completion of this form.

Patient Signature:_____ Date:_____

Parent/Legal Guardian (if under 18):_____ Date:_____