

Patient Name:

Last

First

MI

Preferred Name

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other | <input type="checkbox"/> Allergy - Amox |
| <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro | <input type="checkbox"/> Allergy - Hay Fever |
| <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa |
| <input type="checkbox"/> Allergy Nickel | <input type="checkbox"/> Allergy-Tetracycline | <input type="checkbox"/> Alzheimers/Dementia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes1/2 | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Emphyzema | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Valve | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> No Epi |
| <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke-TIA | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | | |

Do you snore or do you feel tired during the day?

Have there been changes in your health in the past six months, please explain.

Medications, prescribed and over the counter. Include dosage and reason for taking.

I Certify the above information has been accurately provided.

Response Date: