

Patient Name _____
Last First MI

▶ Check (✓) if you have any of the following conditions:

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Crooked Teeth | <input type="checkbox"/> Discoloration |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Clicking/Popping Jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity to Sweets | <input type="checkbox"/> Sores/Growths |
| <input type="checkbox"/> Sensitivity to Hot/Cold | <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Cosmetic Concerns _____ | | |

▶ **ALLERGIES**

Check (✓) if you are allergic to any of the following:

- | | | | | | | |
|----------------------------------|---|--------------------------------------|---------------------------------------|-------------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Codeine | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Metals | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Other _____ | | | |

I have NO ALLERGIC REACTION TO ANY MEDICATIONS/SUBSTANCES at this time

▶ **MEDICATIONS**

List all medications you are currently taking:

Rx _____	taken for _____
Rx _____	taken for _____
Rx _____	taken for _____

I am taking NO MEDICATIONS at this time

▶ **PREGNANCY (For Women)**

Are you pregnant? Yes No Do you suspect pregnancy? Yes No Are you nursing? Yes No

OB/GYN _____ Phone# _____

▶ Check (✓) if you have any of the following conditions:

- | | | | | | | | |
|------------------------|--|---|--|----------------|--|------------------------|--|
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bacterial Endocarditis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, please indicate DATE of surgery _____ | | | | | |

▶ **Are you taking any BLOOD THINNING MEDICATION, such as COUMADIN?** Yes No

▶ **Do you have any ARTIFICIAL JOINTS, PINS, OR PLATES? If yes, please EXPLAIN** _____

If you have answered **Yes** to any of the above conditions, please provide the **NAME OF YOUR TREATING PHYSICIAN:**

Name of Physician _____ Phone# _____

▶ Check (✓) if you have had any of the following conditions:

- | | | | | | |
|-------------------------|--|-----------------------|--|---------------------|--|
| Alcohol Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swelling of Feet/Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cough, Persistent | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cough Up, Blood | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tobacco Habit | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | |

The above information is accurate and complete to the best of my knowledge. I release Dr Garret Uehara and his staff from any and all liability that may arise from any and all omissions or failure to disclose any health information, whether intentional or not.

Patient (or Parent if Patient is a minor) Signature _____ Date _____