Patient Name_____ _____ _____
Last First MI

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

☐Bad Breath ☐Grinding Teeth ☐Loose Teeth ☐Crooked Teeth ☐Discoloration
☐Bleeding Gums ☐Clicking/Popping Jaw ☐Periodontal Treatment ☐Sensitivity to Sweets ☐Sores/Growths
☐Sensitivity to Hot/Cold ☐Food Collection Between Teeth ☐Cosmetic Concerns _____

ALLERGIES

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

☐Aspirin ☐Barbiturates ☐Codeine ☐Erythromycin ☐Penicillin ☐Sulfa ☐Latex
☐Metals ☐Local Anesthetic ☐Epinephrine ☐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 ☐Yes ☐No Heart Murmur ☐Yes ☐No Heart Problems ☐Yes ☐No Mitral Valve Prolapse ☐Yes ☐No
Rheumatic Fever ☐Yes ☐No Stroke ☐Yes ☐No Pacemaker ☐Yes ☐No Bacterial Endocarditis ☐Yes ☐No
Heart Surgery ☐Yes ☐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	☐Yes ☐No	Arthritis, Rheumatism	☐Yes ☐No	Chemical Dependency	☐Yes ☐No
Cortisone Treatments	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No
Swelling of Feet/Ankles	☐Yes ☐No	Respiratory Disease	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Back Problems	☐Yes ☐No	Blood Problems	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Cough, Persistent	☐Yes ☐No	Cough Up, Blood	☐Yes ☐No
Kidney Disease	☐Yes ☐No	Liver Disease	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Tobacco Habit	☐Yes ☐No	Venereal Disease	☐Yes ☐No	Hemophilia	☐Yes ☐No
Jaw Pain	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Ulcer	☐Yes ☐No
Asthma	☐Yes ☐No	Hypertension	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Skin Rash	☐Yes ☐No	Diabetes	☐Yes ☐No	Cancer	☐Yes ☐No
Epilepsy	☐Yes ☐No	Tonsillitis	☐Yes ☐No	Fainting	☐Yes ☐No
Glaucoma	☐Yes ☐No	Hepatitis	☐Yes ☐No	Anemia	☐Yes ☐No
HIV/AIDS	☐Yes ☐No	Headaches	☐Yes ☐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_____