

# PATIENT MEDICAL HISTORY

Patient's Name:	By what name do you prefer to be called?	For Office Use Only I.D. <input type="text"/>
-----------------	--	--

Address:	Today's Date:	Date of Last Dental Visit:
----------	---------------	----------------------------

City State Zip:	Email:	Cell Phone:
-----------------	--------	-------------

Home Phone:	Work Phone:	Birth Date:	Social Security No.:	Marital Status:
-------------	-------------	-------------	----------------------	-----------------

Are you a college student? <input type="checkbox"/> Y <input type="checkbox"/> N	Name and address of the college: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
--	--

Employer:	Employer Address:
-----------	-------------------

Has your name changed in the last 3 years?
--

Are other family members patients here?
---

Whom may we thank for referring you?
--------------------------------------

Who is responsible for this account?	Home Phone:	Relationship to Patient:
--------------------------------------	-------------	--------------------------

<b>Primary Insurance:</b> Name of Insured:	Home Phone:	Work Phone:
--	-------------	-------------

Date of Birth:	Social Security #:	Relationship to Patient:
----------------	--------------------	--------------------------

Employer:	Employer Address:
-----------	-------------------

Insurance Co.:	Address:
----------------	----------

Insurance Group #:	Insurance Co. Phone:
--------------------	----------------------

<b>Secondary Insurance:</b> Name of Insured	Home Phone:	Work Phone:
---	-------------	-------------

Date of Birth:	Social Security #:	Relationship to Patient:
----------------	--------------------	--------------------------

Employer:	Employer Address:
-----------	-------------------

Insurance Co.:	Group #	Address:
----------------	---------	----------

<b>Previous Dentist:</b>	<b>Phone:</b>	<b>Physician Name:</b>	<b>Phone:</b>
--------------------------	---------------	------------------------	---------------

<b>Pharmacy:</b>	<b>Pharmacy Phone:</b>
------------------	------------------------

<b>Sex:</b>	<b>If female, please answer the following:</b>	<b>Please answer the following:</b>																								
<input type="checkbox"/>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;"><b>Y</b></td> <td style="width:5%;"><b>N</b></td> <td style="width:40%;"><input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills</td> <td style="width:15%;">If Yes, # of weeks</td> <td style="width:15%;"><input type="text"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> <input type="checkbox"/> Are you pregnant?</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> <input type="checkbox"/> Are you nursing?</td> <td></td> <td></td> </tr> </table>	<b>Y</b>	<b>N</b>	<input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills	If Yes, # of weeks	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Are you pregnant?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Are you nursing?			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;"><b>Y</b></td> <td style="width:5%;"><b>N</b></td> <td style="width:90%;"><input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco?</td> </tr> <tr> <td colspan="3"><b>For Office Use Only</b></td> </tr> <tr> <td>BP</td> <td><input type="text"/></td> <td>Heart Rate <input type="text"/></td> </tr> </table>	<b>Y</b>	<b>N</b>	<input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco?	<b>For Office Use Only</b>			BP	<input type="text"/>	Heart Rate <input type="text"/>
<b>Y</b>	<b>N</b>	<input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills	If Yes, # of weeks	<input type="text"/>																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Are you pregnant?																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Are you nursing?																								
<b>Y</b>	<b>N</b>	<input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco?																								
<b>For Office Use Only</b>																										
BP	<input type="text"/>	Heart Rate <input type="text"/>																								

<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;"><b>Y</b></td> <td style="width:5%;"><b>N</b></td> <td style="width:90%;"><b>Conditions</b></td> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abnormal Bleeding</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Alcohol Abuse</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Anemia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Angina Pectoris</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Artificial Joints</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Artificial Heart Valve</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Blood Transfusion</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cancer – Chemotherapy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Colitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Congenital Heart Defect</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cosmetic Surgery</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Difficulty Breathing</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Drug Abuse</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Emphysema</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Epilepsy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fainting Spells</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fever Blisters</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Frequent Headaches</td></tr> </table>	<b>Y</b>	<b>N</b>	<b>Conditions</b>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Cancer – Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;"><b>Y</b></td> <td style="width:5%;"><b>N</b></td> <td style="width:90%;"><b>Conditions</b></td> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Glaucoma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hay Fever</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Attack</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Murmur</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Surgery</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hemophilia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hepatitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>High Blood Pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>HIV + AIDS</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Kidney Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Liver Disease</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Low Blood Pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Mitral Valve Prolapse</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pace Maker</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pneumocystitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Psychiatric Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Radiation Therapy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Seizures</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Shingles</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sickle Cell Disease</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sinus Problems</td></tr> </table>	<b>Y</b>	<b>N</b>	<b>Conditions</b>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	HIV + AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Pneumocystitis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;"><b>Y</b></td> <td style="width:5%;"><b>N</b></td> <td style="width:90%;"><b>Conditions</b></td> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Stroke</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Thyroid Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tuberculosis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ulcers</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Venereal Disease</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Yellow Jaundice</td></tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;"><b>Y</b></td> <td style="width:5%;"><b>N</b></td> <td style="width:90%;"><b>Allergies</b></td> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Aspirin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Codeine</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dental Anesthetics</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Erythromycin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Household Bleach</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Jewelry</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Latex</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Metals</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Penicillin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tetracycline</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sulfa</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>_____</td></tr> </table>	<b>Y</b>	<b>N</b>	<b>Conditions</b>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<b>Y</b>	<b>N</b>	<b>Allergies</b>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Household Bleach	<input type="checkbox"/>	<input type="checkbox"/>	Jewelry	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Y</b>	<b>N</b>	<b>Conditions</b>																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Allergies																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Anemia																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Asthma																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Cancer – Chemotherapy																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Colitis																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches																																																																																																																																																																																																						
<b>Y</b>	<b>N</b>	<b>Conditions</b>																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	HIV + AIDS																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Pneumocystitis																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Seizures																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Shingles																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems																																																																																																																																																																																																						
<b>Y</b>	<b>N</b>	<b>Conditions</b>																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Stroke																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice																																																																																																																																																																																																						
<b>Y</b>	<b>N</b>	<b>Allergies</b>																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Codeine																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Household Bleach																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Latex																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Metals																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Sulfa																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	_____																																																																																																																																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	_____																																																																																																																																																																																																						

<b>Medications - Check any you are or have taken:</b>	<b>Please list any other medications you are taking:</b>
<input type="checkbox"/> Anticoagulants <input type="checkbox"/> Aspirin <input type="checkbox"/> Blood Thinners <input type="checkbox"/> Cortisone Drugs <input type="checkbox"/> Sedatives <input type="checkbox"/> Steroids <input type="checkbox"/> Tranquilizers	

<b>Y</b>	<b>N</b>	<input type="checkbox"/> <input type="checkbox"/> Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...

<b>Notes:</b>	
---------------	--

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (If under 18, Parent or Guardian signature required)