

Medications   
 Allergies   
 Conditions   
 More Conditions   
 BP/Weight/Physician/etc

**NAME:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

Under a physician's Care:

Physician's Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

**Medications**

**Please list all medications and dosage if known including over the counter medications or herbal supplements.**

Standard Medications

<input type="checkbox"/> No Medications	Name of Medication	<input type="checkbox"/> Birth Control Pills	Name of Medication
<input type="checkbox"/> Antibiotic	_____	<input type="checkbox"/> Insulin	_____
<input type="checkbox"/> Pain Medicine	_____	<input type="checkbox"/> Ulcer/Nexium	_____
<input type="checkbox"/> Heart Medicine	_____	<input type="checkbox"/> Bone Related/Bisphosphor	_____
<input type="checkbox"/> Aspirin	_____	<input type="checkbox"/> Antidepressants	_____
<input type="checkbox"/> Cortisone/Steroids	_____	<input type="checkbox"/> Steroids	_____
<input type="checkbox"/> Blood Thinner	_____	<input type="checkbox"/> Asthma/COPD	_____
<input type="checkbox"/> Blood Pressure	_____	<input type="checkbox"/> Infectious	_____
<input type="checkbox"/> Hormone	_____	<input type="checkbox"/> Seasonal	_____
<input type="checkbox"/> Thyroid	_____	<input type="checkbox"/> Herbal supplements	_____

Specific Medications

_____	for	_____
_____	for	_____
_____	for	_____
_____	for	_____
_____	for	_____

List of Medications

\_\_\_\_\_

You may provide a pre-written medication list if it is more convenient for you.

Medications   
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**Allergies**

<input type="checkbox"/> Penicillin	Reaction	<input type="checkbox"/> Food	Reaction
<input type="checkbox"/> Antibiotics	_____	<input type="checkbox"/> Bleach	_____
<input type="checkbox"/> Aspirin	_____	<input type="checkbox"/> Iodine/Seafood	_____
<input type="checkbox"/> Tylenol	_____	<input type="checkbox"/> Seasonal	_____
<input type="checkbox"/> Sulfa	_____	<input type="checkbox"/> Metal	_____
<input type="checkbox"/> Narcotics	_____	<input type="checkbox"/> Sulfa	_____
<input type="checkbox"/> Local Anesth Novocaine/Li	_____	<input type="checkbox"/> Seasonal	_____
<input type="checkbox"/> Latex	_____	<input type="checkbox"/>	_____
<input type="checkbox"/> Valium	_____	<input type="checkbox"/>	_____
<input type="checkbox"/> Nitrous Oxide	_____	<input type="checkbox"/>	_____

List of Allergies

\_\_\_\_\_

Please check all that apply

Medications Allergies **Conditions** More Conditions BP/Weight/Physician/etc

Conditions

Conditions	Status	Conditions	Status
<input type="checkbox"/> High Blood Pressure	<input type="text"/>	<input type="checkbox"/> Heart Attack	<input type="text"/>
<input type="checkbox"/> Stroke	<input type="text"/>	<input type="checkbox"/> Arrhythmias	<input type="text"/>
<input type="checkbox"/> Pacemaker	<input type="text"/>	<input type="checkbox"/> Rheumatic Fever	<input type="text"/>
<input type="checkbox"/> Heart Murmur	<input type="text"/>	<input type="checkbox"/> Heart Valve Replacement	<input type="text"/>
<input type="checkbox"/> Artificial Joint	<input type="text"/>	<input type="checkbox"/> Asthma	<input type="text"/>
<input type="checkbox"/> COPD	<input type="text"/>	<input type="checkbox"/> Lung Disease	<input type="text"/>
<input type="checkbox"/> Cancer or Tumor	<input type="text"/>	<input type="checkbox"/> Radiation/Chemotherapy	<input type="text"/>
<input type="checkbox"/> Kidney Disease	<input type="text"/>	<input type="checkbox"/> Hepatitis or Liver Disease	<input type="text"/>
<input type="checkbox"/> Diabetes	<input type="text"/>	<input type="checkbox"/> Thyroid Disease	<input type="text"/>
<input type="checkbox"/> Epilepsy or Seizures	<input type="text"/>	<input type="checkbox"/> AIDS/HIV-positive	<input type="text"/>

General Notes

Medications Allergies Conditions **More Conditions** BP/Weight/Physician/etc

More Conditions

More Conditions	Status	More Conditions	Status
<input type="checkbox"/> Arthritis	<input type="text"/>	<input type="checkbox"/> Other Heart Disease	<input type="text"/>
<input type="checkbox"/> Ulcers/Digestive	<input type="text"/>	<input type="checkbox"/> Bleeding disorder	<input type="text"/>
<input type="checkbox"/> Migraine/Headaches	<input type="text"/>	<input type="checkbox"/> Anxiety	<input type="text"/>
<input type="checkbox"/> Fainting	<input type="text"/>	<input type="checkbox"/> Tuberculosis	<input type="text"/>
<input type="checkbox"/> Glaucoma/Visual	<input type="text"/>	<input type="checkbox"/> Systemic Lupus	<input type="text"/>
<input type="checkbox"/> Bisphosphonate meds	<input type="text"/>	<input type="checkbox"/> Prosthetic Implant	<input type="text"/>
<input type="checkbox"/> Tobacco use	<input type="text"/>	<input type="checkbox"/> Any Transplant	<input type="text"/>
<input type="checkbox"/> Alcoholism/Addiction	<input type="text"/>	<input type="checkbox"/> Pregnancy/Nursing	<input type="text"/>
<input type="checkbox"/> Infectious Diseases	<input type="text"/>	<input type="checkbox"/> TMJ/Jaw	<input type="text"/>
<input type="checkbox"/> Venereal Disease	<input type="text"/>	<input type="checkbox"/> Excessive/Abnormal Bleedi	<input type="text"/>
<input type="checkbox"/> Psychiatric Care	<input type="text"/>		
<input type="checkbox"/> Other	<input type="text"/>		

Details

Dental complications     Other     Facial Trauma

General Notes