

IV. DO YOU HAVE OR HAVE YOU HAD:

- 1. Psychiatric Care?..... Y N
- 2. Radiation treatment? Y N
- 3. Chemotherapy? Y N
- 4. Prosthetic heart valve? Y N
- 5. Hospitalization? Y N
- 6. Blood transfusions? Y N

- 7. Surgeries? Y N
- 8. Pacemaker? Y N
- 9. Contact lenses? Y N
- 10. Artificial joints? Y N
- If yes, what joints? _____
- When? _____
- Were you instructed to take pre-medications? .Y N

V. ARE YOU TAKING:

- 1. Recreational drugs? Y N
- 2. Drugs medications, over the counter medicines
(including Aspirin) or natural remedies?. Y N
- 3. Tobacco in any form? Y N
- 4. Alcohol? Y N

- 5. Blood thinners? Y N
- Coumadin/Warfarin, Heparin/Lovenox, Plavix, Xarelto,
Aspirin? Y N
- If yes, how long on medication? _____
- Why on medication? _____
- Last time you have seen prescribing Doctor? _____

Please list all medications or natural remedies below in section VIII.

VI. WOMEN ONLY:

- 1. Are you or could you be pregnant or nursing?.... Y N
- 2. Taking birth-control? Y N

VII. ALL PATIENTS:

- 1. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest,
or shortness of breath, or because you are Very tired? Y N
- 2. Have you lost or gained more than 10 pounds in the past year?) Y N
- 3. Do you ever wake up from sleep short. of breath? Y N
- 4. Do you or have you had any other disease or medical problem NOT listed on this form? Y N
- If so, please explain: _____

VIII. IF YOU ARE TAKING MEDICATIONS, PLEASE LIST:

Name of Medication	Dose	Directions	How Long on Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- 1. Are you allergic or have you reacted adversely to any of the following substances: (Please check if Y)..... Y N
- Local Anesthetic Aspirin or Ibuprofen Valium Penicillin/Amoxicillin Scopolamine
- Codeine or other narcotics Latex Iodine Other Antibiotics
- 2. Are you aware of being allergic to any other medication or substance not listed? Y N
- 3. PLEASE DESCRIBE YOUR REACTION TO THE ALLERGEN: _____

CONSENT:

I certify the above information is true to the best of my knowledge. The undersigned hereby authorize Dr Backer / Dr. Slaybaugh to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr Backer / Dr. Slaybaugh to make a thorough diagnosis of the patient’s dental needs.

PATIENT _____ **DATE** _____ **DOCTOR/WITNESS** _____

Parent or Responsible Party _____ Relationship to Patient _____