Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_

Yes No Allergies Medications: Please List

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Penicillin | 1) | 6) |
|  |  | Antibiotics | 2) | 7) |
|  |  | Sulfa Drugs | 3) | 8) |
|  |  | Latex | 4) | 9) |
|  |  | Other: | 5) | 10) |

Please check Yes or No:

Yes No Yes No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | High Blood Pressure |  |  | Asthma |
|  |  | Heart Attack |  |  | Leukemia |
|  |  | Heart Disease |  |  | Seizures/Fainting |
|  |  | Cardiac Pacemaker |  |  | HIV infection/AIDS |
|  |  | Stroke |  |  | Abnormal Bleeding |
|  |  | Diabetes |  |  | Angina |
|  |  | Radiation Therapy |  |  | Liver Disease |
|  |  | Kidney Disease |  |  | Emphysema/COPD |
|  |  | Cancer |  |  | Total Joint Replacement |
|  |  | Bisphosphonate Use |  |  | Pregnant or Nursing |
|  |  | Diagnosed Sleep Apnea |  |  | CPAP-BIPAP use |
|  |  | Have you ever had a sleep study? |  |  | TMJ discomfort or headaches |

Please list any other medical condition not listed:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_