Patient Name:________________________________ **Height:**________ **Weight:**__________

Martial Status: __________

Father: Living _____ **Deceased** _____ **Mother: Living** ______ **Deceased**______

	Yes	No			
Do you or have you ever smoked? If yes , years?____			Number packs/per day________ Last Smoked?________		
Do you drink alcoholic beverages on a weekly basis			Yes, How much?______________		
Do you use Marijuana __ Cocaine __ Heroin__ other___			If yes, how often_____ When was the last time used ____		
Do you have a Medical Marijuana Card					
Do you have or have you ever had any of the following?	**Yes**	**No**		**Yes**	**No**
Diabetes			Do you get cold sore/fever blisters		
Sleep Apnea			History of Bleeding or Bruising		
Pacemaker/ICD			Excess Bleeding from Surgery		
Do you have an Advance Care Directive			Ultrasound of the Heart (Echo)		
Breast Cancer			An exam by a cardiologist (heart doctor)		
Had a mammogram done. If yes, Year ______			Heart Catheterization		
Have you had Flu Vaccine			Irregulart Heart Beat, Palpitations/A-Fib		
Have you had Pneumonia Vaccine			Blood Transfusion		
Any loose or chipped teeth			Phlebitis/Blood Clots		
Caps/Bridges/Dentures/Root Canal/Crowns			Hearing Aid		
Temporal Mandibular Joint Disease			Glasses/ Contacts		
History of Asthma			Infectious Disease		
Tuberculosis			Heart Failure		
High Blood Pressure			Heart Valve DisorderBypass/Stents		
Chest Pain			Do you take Pre-Dental Antibiotics		
Have you gained 10-15 pound in the last year?			Stomach Ulcer		
Do you have excessive daytime sleepiness?			Kidney Disorder		
Epilepsy/Seizures			Thyroid Disorder		
History of Anemia			Liver Disease, Jaundice, Hepatitis		
Stroke			Multiple Scleroisis or Polio		
Sickle-Cell Anemia/Trait			Head Injury		
Rheumatic Fever			Scoliosis		

List Allergies to medication; ____________________ **LATEX ALLERGY?:**__________

____

____

____

List all medications you are taking and dosage Medication continued

______________________________ ______________________________

______________________________ ______________________________

List all previous Surgeries : Year **Reason**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

X ______________________________ **X** ______________________________

Signature of Patient, Parent, or Legal Guardian Date