GRABER DENTAL

Patient Name: _____ _____ ____ _____

Last **First** **MI** **Preferred Name**

Are you allergic to any of the following:

□ Aspirin □ Codeine □ Metal □ Penicillin □ Other _____

Do you have, or have you had, any of the following conditions?

□ Anemia	□ Anxiety/Depression	□ Arthritis/Gout	□ Artificial Joints
□ Asthma	□ Blood Disease	□ Cancer	□ COPD
□ Diabetes	□ Dizziness	□ Epilepsy	□ Excessive Bleeding
□ Fainting	□ Frequent Headaches	□ GERD/Heartburn	□ Glaucoma
□ Heart Disease	□ Heart Valve replacement	□ High blood pressure	□ High Cholesterol
□ Kidney Disease	□ Liver Disease	□ Pacemaker	□ Radiation Treatment
□ Respiratory Problems	□ Sinus Problems	□ Sleep Apnea	□ Stroke
□ Stomach problems	□ Thyroid Problems	□ Tobacco Use	□ Alcohol Use
□ Tuberculosis	□ Ulcers	□ Other _____	

Women – Please check all that apply to you:

□ Pregnant □ Trying to get pregnant □Taking Birth Control □ Nursing

Do you take antibiotic premedication for your dental visits? _____If yes please explain:

_____

Name of your physician and phone number: _____

Are you currently under the care of a physician of any kind for medical treatment, impending surgeries, or other treatment? _____ If yes, please list any and all details available:

_____

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin or daily vitamins: □ Yes □ No

Are you currently or have you taken any type of **Bisphosphonates** for osteoporosis or chemotherapy? □ Yes □ No

Brands of Bisphosphonates include: Fosamax, Alendronate, Actonel, Risedronate, Boniva, Zometa, Didronel, Aredia, etc.

Please list any medications you are currently taking: _____

_____

Signature _____ **Date** _____