**Robert Karelitz D.D.S**

**Liza King D.M.D.**

**Patrick Carroll D.M.D.**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL HISTORY

Yes No Yes No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Heart (surgery, disease, attack) |  |  | Lung Disease |  |  |
| Chest Pain |  |  | Kidney Disease |  |  |
| Congenital Heart Defect/Disease |  |  | Liver Disease |  |  |
| Pacemaker |  |  | Blood Disorder (excessive bleeding, etc) |  |  |
| High Blood Pressure |  |  | AIDS/HIV positive |  |  |
| Artificial Heart Valve Year: |  |  | Hepatitis |  |  |
| Stroke |  |  | Human Papillomavirus (HPV) |  |  |
| Arthritis |  |  | Cancer |  |  |
| Joint Replacement Year: |  |  | Radiation/Chemotherapy |  |  |
| Diabetes |  |  | Epilepsy |  |  |
| Thyroid Condition |  |  | Psychological Disorder (i.e. autism, depression) |  |  |
| Glaucoma |  |  | Asthma |  |  |
| Osteoporosis |  |  | Sinus Problems |  |  |
| Sleep Apnea |  |  | Drug/Alcohol Addiction |  |  |
| Dizziness |  |  | Other: |  |  |

Is there anything else we need to know about your medical history? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Women: Are you: Taking birth control pills? Yes No

Pregnant? Yes No

MEDICATIONS

Are you taking or have you ever taken: Anticoagulants (Coumadin, Warfarin, etc) Yes No

Bisphosphonates (Oral, IV or Injection) Yes No

Antibiotic Prophylaxis before dental treatment Yes No

Please list all current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you currently under the care of a medical doctor? Yes No

Physician’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to latex? Yes No

Please list all allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of patient and/or guardian Date