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 Primary Care Physician? Yes No

Physician's name_________________________________ City, State_________________________________

Are you allergic to latex? Yes No

Please list all allergies:____

____ __________________________

Signature of patient and/or guardian Date