Brian R. Saklofsky, D.M.D., P.C.

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Patient Name: ______________________ ______________________ ___ ______________

Last First MI Preferred Name

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and phone number:

____

____

Please list pharmacy name, number and location:

____

____

Emergency Contact Name, Phone Number, and relationship to patient: *

____

____

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Acid Reflux	☐ AIDS	☐ Alcoholism	☐ Anemia
☐ Asthma	☐ Breathing Difficulty	☐ Cancer*	☐ Circulatory Problems
☐ COPD	☐ Diabetes*	☐ Dizziness	☐ Drug Addiction
☐ Eating Disorder*	☐ Emphysema	☐ Excessive Bleeding	☐ Excessive Thirst
☐ Fainting	☐ Glaucoma	☐ Headaches	☐ Heart Attack
☐ Heart Burn	☐ Heart Murmur	☐ Heart Valve Replaced	☐ Hepatitis*
☐ Herpes	☐ High Blood Pressure	☐ HIV	☐ Joint Replacement*
☐ Kidney Disease	☐ Knee replacement	☐ Liver Disease	☐ Low Blood Pressure
☐ Mental Disorder*	☐ Migraines	☐ Nervous Disorder*	☐ Organ Transplant*
☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Seizures	☐ Sinus Problems
☐ Sleep Apnea	☐ Stent	☐ STI	☐ Stomach Problems*
☐ Stroke	☐ Tetanus shot	☐ Thyroid Condition*	☐ Tobacco Use*
☐ Tuberculosis	☐ Ulcers		

Please provide additional information for any condition marked with an asterisk.
If any conditions or alerts selected above need further clarification OR if there are any unlisted conditions, please describe below:

____

____

____

____

____

Have you ever been hospitalized or diagnosed for a serious medical condition? * ○ Yes ○ No

- If you answered "yes" to the previous question please explain:

____
____
____

Please list any medications you are currently taking, one medication per line:

____
____
____
____
____

Please list ANY allergies (including medications, dental anesthetics, foods, ect):

____
____

Do you take, or have you ever been asked to take, an antibiotic prior to a dental appointment? * ○ Yes ○ No

- If you answered "yes" to the previous question, please explain:

____
____

Are you currently pregnant? * ○ Yes ○ No

Are you currently nursing? * ○ Yes ○ No

Are you currently on birth control? * ○ Yes ○ No

- If you answered "yes" to previous question, please list type:

____
____

☐ **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Response Date: ____________