



Patient Name: Last First MI Preferred Name

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> *Premed-amox | <input type="checkbox"/> *Premed-clynd | <input type="checkbox"/> Acrylic Allergy | <input type="checkbox"/> Alcohol Addiction |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Allergy Penicillin | <input type="checkbox"/> Alzhiemers/Dementia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial Heart Val | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Aspirin Allergy | <input type="checkbox"/> Aspirin therapy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> C.O.P.D | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Codine Allergy | <input type="checkbox"/> Cold Sore/Fever Blis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hemophelia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Iodine Allergy | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Missing type |
| <input type="checkbox"/> Mycin Allergy | <input type="checkbox"/> NO EPINEPHRINE | <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Premed Other | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stent | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sulfa Allergy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors/Growths | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease |

Medications or other health complications not listed above/list any allergies:

Patients Signature

Signature: _____

Date:

Doctors Signature

Signature: _____

Date:

Response Date:

