KEYSTONEDENTALPRACTICE.COM

Name_____ **Signature**_____ **Date** _____
Address_____
_____ **Date of Birth**_____

ALL information is needed for our records and is considered confidential
Do you have or have you had any of the following medical conditions?
Please check the box and add date of diagnosis or treatment

- ☐ Anemia
- ☐ Anxiety
- ☐ Arnold-Chiari
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism
- ☐ Back Problems
- ☐ Bipolar
- ☐ Bleeding Abnormally
- ☐ Paralysis
- ☐ Blood Disease
- ☐ BPH/Enlarged Prostate
- ☐ Cancer (type)
- ☐ Cataract Surgery
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Congestive Heart Failure
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough up blood
- ☐ Cough, persistent
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Deep Vein Thrombosis
- ☐ Dystonia
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Guillain-Barre Syndrome
- ☐ GERD
- ☐ Glaucoma
- ☐ Growth Hormone Deficiency
- ☐ Headaches
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hemochromatosis
- ☐ Hemophilia
- ☐ Hepatitis (type)
- ☐ Hernia Repair
- ☐ High Blood Pressure/HTN
- ☐ Hip Replacement
- ☐ HIV/AIDS
- ☐ Hyperlipidemia
- ☐ Irritable Bowel Syndrome
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Knee/Hip Replacement
- ☐ LUPUS
- ☐ Mild MR
- ☐ Mitral Valve Prolapse
- ☐ Neuropathy
- ☐ OCD (obsessive compulsive disorder)
- ☐ Organic Affective Syndrome
- ☐ Osteoarthritis
- ☐ Pacemaker
- ☐ Para Pareti Spastic Quad
- ☐ Parkinson's Disease
- ☐ PDD (pervasive developmental disorder)
- ☐ PLS (primary lateral sclerosis)
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure Disorder
- ☐ Shortness of Breath
- ☐ Sinusitis
- ☐ Skin Rash
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Swelling
- ☐ Thyroid Problems
- ☐ Tobacco Habit (nicotine)
- ☐ Tonsillitis
- ☐ Tourette's Syndrome
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease (type)
- ☐ Venous Insufficiency
- ☐ Vertigo
- ☐ Substance Abuse (past/present)
  Alcohol, Prescription drug, Non-Prescription drug, OTC drug
  Substance name:_____

Other Conditions: _____
_____
_____

Allergies- please check the box

☐ ***NKDA (No Known Drug Allergies)***

- ☐ Acetaminophen
- ☐ Amoxicillin
- ☐ Augmentin
- ☐ Azithromycin (Z-Pak)
- ☐ Clindamycin
- ☐ Flagyl (Metronidazole)
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other (list below)

*Other Allergies:*_____

Medications- please list: _____
_____
_____
_____

What main pharmacy do you use? _____

Women: *Are you pregnant?* ☐ No ☐ *Yes* *How Many Weeks?*_____

- ☐ **Employed** - Job Title_____
- ☐ **Retired** - Previous Job Title_____
- ☐ **Unemployed**