Name: _____ Age: _____

Name of Physician: _____ Most recent exam: _____

Do you have an allergy to any of the following:

antibiotics _____ Y N

aspirin, ibuprofen, acetaminophen or codeine _____ Y N

local anesthetic _____ Y N

chlorhexidine _____ Y N

red dye _____ Y N

other _____ Y N

Have you had heart problems or a cardiac stent within the last 6 months? _____ Y N

Do you have a history of infective endocarditits?_____ Y N

Do you have an artificial heart valve? _____ Y N

Are you taking a statin medication?_____ Y N

Do you have a joint replacement?_____ Y N

Do you have high or low blood pressure? _____ Y N

Have you had a stroke, or are you taking blood thinners? _____ Y N

Do you have asthma? _____ Y N

Do you have sleep apnea, or do you snore?_____ Y N

Do you have diabetes?_____ Y N

if so, what is your HbA1c? _____

Do you have a digestive or eating disorder or have you had bariatric surgery? ____ Y N

Have you ever taken an anti-resorptive medication (bisphosphonate)? _____ Y N

Do you have an autoimmune disease? _____ Y N

Do you have epilepsy or seizures? _____ Y N

Do you get cold sores? _____ Y N

Do you have any lumps or swelling in your mouth? _____ Y N

Do you have hepatitis? _____ Y N

Do you have HIV or AIDS? _____ Y N

Do you have cancer, or have you had chemotherapy or radiation therapy? _____ Y N

Do you use tobacco, cannabis or vape? _____ Y N

Are you considered a touchy or sensitive person? _____ Y N

Are you currently pregnant? _____ Y N

Are you presently being treated for any other illness? _____ Y N

Please list all medications and supplements you are taking

_____

_____

_____

Patient Signature _____ Date _____

Doctor Signature _____ Date_____