GOEDECKE
FAMILY DENTISTRY

Primary Care Physician:_____ Date of Last Visit:_____

Mark with an "X" any of the following for which you have ever been treated/conditions that apply to you:

__Anemia
__Anxiety
__Arthritis/Rheumatism
__Artificial Heart Valve
__Artificial Joint
__Asthma/Respiratory Problems
__Blood Disease/Hemophilia
__Cancer/Tumor
__Circulatory Problems
__Cough,Persistent
__Diabetes – Type1__ Type2__
__Epilepsy/Seizures
__Fainting
__Headaches/Migraines
__Heart Problems
__Hepatitis- TypeA__ B__
__High or__Low Blood Pressure
__HIV/AIDS
__Jaw Pain/TMJ
__Kidney Disease
__Liver Disease
__Lupus
__Mitral Valve Prolapse
__Osteoporosis
__Scarlet Fever
__Sleep Apnea
__Stroke
__Thyroid Problems
__Tobacco Habit
__Tonsillitis
__Tuberculosis
__Venereal Disease

If you checked "heart problems,' please explain:_____

List any other serious illnesses, conditions,operations:_____

Current Medications (if none, write "NONE"):_____

Are you taking or have you recently stopped taking blood thinners?__Y __N

Have you ever been told you needed to take an antibiotic prior to dental treatment? __Y __N If so, for what?_____

Allergies (Mark with an "X" any that apply):

__None __Aspirin __Barbiturates(Sleeping Pills) __Codeine __Local Anesthesia __Penicillin __Sulfa __Latex

__Other:_____

Have you ever taken any medication for osteoporosis? __Y __N If so, please list:_____

Mark with an "X" any of the following "fen-phen" drugs you have ever taken:

__Lonimin Adipex __Fastin (Phentermine) __Podimin (Fenflurmine) __Redux (Dexfenfluramine) __None

***FOR WOMEN ONLY- Mark with an "X" any that apply:**

__Pregnant __Nursing __Taking Birth Control Pills __None of These

_____
Patient Name (Printed)

_____ _____
Patient/Guardian Signature Date