Topeka Dentistry

Patient name_____ Height _____ Weight _____

Name and phone # of physician _____

List all medications you are currently taking

_____

Due to a medical condition, have you ever been told to take antibiotics prior to dental treatment?
If so please indicate for what condition you pre-medicate
_____

Please circle any **illnesses** you have or have had:

Acid reflux	Artificial joint	Asthma	Bleeding disorder
Cancer	Diabetes type I or II		Epilepsy
Heart attack	Heart disease	Hepatitis	HIV/AIDS
High blood pressure	Kidney disease	Liver disease	
STD/STI	Sleep apnea	Stroke	Thyroid condition
Vertigo	Other _____		

Do you use tobacco or smoke? Yes or no

Are you **allergic** or sensitive to any of the following?

Codeine Penicillin Sulfa Drugs Lidocaine Latex Other _____

Please indicate any other information that we should know about your health._____

_____

I understand that by signing this form I am giving consent for treatment by Topeka Dentistry.

Signature of patient or representative and date