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Patient Name_____ Today's Date_____

Date of Birth _____/_____/_____

Please √ YES or NO to the following questions: They are for our records and will be kept confidential.

	YES	NO
1. Are you in good health?	☐	☐
2. Date of last physical exam _____.		
3. Are you presently under the care of a physician?	☐	☐
4. Have you ever had serious illness or serious operations?	☐	☐

If so, what and when?_____

5. Name of your physician_____Phone#_____

6. Have you ever had or do you have any of the following:?

YES NO

☐ ☐ Heart Problems/murmurs
Describe:_____
_____
☐ ☐ Hip, knee or other joint implant
☐ ☐ Do you require antibiotics before dental treatment?
☐ ☐ High/low blood pressure
☐ ☐ Asthma/hay fever
☐ ☐ Seizures/fainting spells
☐ ☐ Diabetes
☐ ☐ Stomach ulcers
☐ ☐ Hepatitis/liver disease: type_____
☐ ☐ Osteo or rheumatoid arthritis
☐ ☐ Kidney problems
☐ ☐ Cancer
location_____
type of treatment _____
☐ ☐ Bleed/bruise easily
☐ ☐ Fever Blisters/mouth ulcers
☐ ☐ Tested for HIV
Positive ☐ Negative ☐
☐ ☐ Contact Lenses
(circle one) Hard Soft
☐ ☐ Glaucoma
☐ ☐ For women-Pregnant?
How many months? _____

NOTES:

Please Turn Page Over

7. Are you taking any of the following drugs or medicine?

YES	NO		YES	NO	
☐	☐	Antibiotics	☐	☐	Herbal supplements_____
☐	☐	Sulfa Drugs	☐	☐	Heart Medication _____
☐	☐	Cortisone	☐	☐	Nitroglycerin
☐	☐	Steroids	☐	☐	Blood Thinners _____
☐	☐	Aspirin	☐	☐	Blood pressure med. _____
☐	☐	Antihistamines	☐	☐	Tranquilizers _____
☐	☐	Insulin, Glucophage, Glucotrol, Glynase or Similar drug	☐	☐	Oral contraceptives _____
			☐	☐	Other hormonal therapy
			☐	☐	Any other drug not listed_____

8. Have you **ever** received or are you presently receiving medications known as Bisphosphonate drugs to treat osteoporosis? ie: Fosomax, Boniva, Zometa, Actonel, Aredia etc...
Please check one: _____Yes _____No

9. Are you allergic or do you act adversely to any of the following?

YES	NO		YES	NO	
☐	☐	Local Anesthetic What kind?_____	☐	☐	Antihistamine
			☐	☐	Codeine
☐	☐	Penicillin	☐	☐	Other antibiotics or drugs
☐	☐	Sulfa Drugs			What? _____
☐	☐	Barbiturates	☐	☐	Latex or latex products
☐	☐	Sleeping pills	☐	☐	Foods _____
☐	☐	Aspirin	☐	☐	Kiwi, bananas, avocado or water chestnuts
☐	☐	Iodine			

10. Please list any other disease or condition that is not listed above that I should be aware of
_____

11. Purpose of this visit? _____

_____ _____

Signature of patient, parent or legal guardian Today's Date

Photo Consent Form

I, _____ grant permission to Robert B. Shelton, DDS. for the use of the photograph(s) or electronic media images as identified below in any presentation of any kind and all kind whatsoever. I understand that I may revoke this authorization at any time by notifying Robert B. Shelton, DDS in writing. The revocation will not affect any actions taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant, and after that time destroyed or archived.

Signature ________________________________ Date _______________________