DR. ELIZABETH J. RESNICK, D.D.S., P.C.

Name: _____ DOB: _____
Physician: _____ Phone: _____
Pharmacy: _____ Phone: _____

Are you allergic, or have you had reactions to any of the following?

O Yes O No Aspirin
O Yes O No Clindamycin
O Yes O No Codeine / Narcotics
O Yes O No Dental Anesthetics
O Yes O No Erythromycin
O Yes O No Latex
O Yes O No Metronidazole (Flagyl)
O Yes O No Penicillin
O Yes O No Tetracycline
O Yes O No Sulfa Drugs

Other drug allergies not listed above _____

Do you have, or have you had, any of the following?

O Yes O No Abnormal Bleeding
O Yes O No Alcoholism/Drug Dependency
O Yes O No Anemia
O Yes O No Angina
O Yes O No Aspirin Daily
O Yes O No Asthma/Emphysema
O Yes O No Artificial Heart Valves
O Yes O No Atrial Fibrillation (A-Fib)
O Yes O No Cancer/Chemotherapy
O Yes O No Cardiovascular Disease
O Yes O No Chronic Bronchitis
O Yes O No Diabetes: Type I or Type II
O Yes O No Epilepsy/Seizures
O Yes O No Heart Attack/Murmur
O Yes O No Heart Pace Maker/Defibrillator
O Yes O No Heart Surgery
O Yes O No Hepatitis A/B/C
O Yes O No High/Low Blood Pressure
O Yes O No HIV/AIDS
O Yes O No Joint Replacement
O Yes O No Kidney Disease
O Yes O No Liver Disease
O Yes O No Mitral Valve Prolapse
O Yes O No Organ Transplant
O Yes O No Psychiatric Problems
O Yes O No Renal Dialysis
O Yes O No Rheumatic Fever
O Yes O No Smoke/Tobacco Use
O Yes O No Stroke
O Yes O No Thyroid Problems
O Yes O No Tuberculosis (T.B.)

Do you have any other medical condition not listed? If yes, please explain

_____

Have you been hospitalized in the last 5 years? If yes, please explain

_____

Has your physician ever told you that you need to take antibiotics before receiving dental treatment? O Yes O No If yes, why _____

PLEASE LIST ALL MEDICATIONS _____

Do you take <u>any</u> **blood thinners** such as Coumadin, Pradaxa, Plavix, or Xarelto? O Yes O No

Do you take, or have you ever taken a bisphosphonate for osteoporosis such as Fosomax, Boniva, Actonel, Reclast, or Prolia? If yes, how long did you take them? _____
Women: Are you Pregnant? O Yes O No **Nursing?** O Yes O No **Take Oral Contraceptives?** O Yes O No

In the event that one of our employees is accidentally exposed to your blood, you may be asked to take a blood test. I certify that the above information is correct to the best of my knowledge and I understand that it is my responsibility to inform this dental office of any changes in my medical status.

Signature: _____ Date: _____