**PATIENT’S NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU CURRENTLY UNDER A PHYSICIAN’S CARE?**  YES / NO

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Name of Treating Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**LIST VITAMINS / SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ALLERGIES TO MEDICATIONS:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:**

A.I.D.S. / A.R.C. / HIV Epilepsy / Seizures Neurological Disorder

Alcoholism Fainting / Dizziness Psychiatric / Mental Health Issues

Allergic Reactions ( medications ) Fever Blisters Pain in Jaw Joints

Anemia Glaucoma Radiation Therapy

Angina Pectoris Heart Disease or Attack Rheumatic Fever

Artificial Heart Value Heart Murmur Shortness of Breath / COPD

Artificial joints / hips / knees Heart Pacemaker Sickle Cell

Arthritis / Rheumatism Hemophilia Sinus Trouble

Asthma / Hay fever / Allergies Hepatitis A / B / C Stroke

Blood transfusions High / Low Blood Pressure Swelling / Edema

Bruise Easily Liver Disease Tonsil / Adenoid Problems

Chemotherapy Jaundice Thyroid Disease

Diabetes Kidney Problems Tuberculosis

Drug addictions Mitral Valve Prolapse Ulcers

Emphysema Nervousness / Anxiety Veneral Disease

**DIET / HEALTH**

Do you frequently skip breakfast? YES / NO

Is your diet medically supervised? YES / NO

Have you had significant weight change in last year? YES / NO # of Lbs lost: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take vitamin or mineral supplements? YES / NO

Do you drink coffee? YES / NO # of cups per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink soda / pop, energy drinks? YES / NO # per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise daily? YES / NO

 Explain what your exercise consists of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke or use tobacco products? YES / NO # per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use a vapor pipe? YES / NO # of times used per day: \_\_\_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages? YES / NO # per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SLEEP HABITS**

Do you sleep with more than two (2) pillows? YES / NO

Do you sleep with your bed elevated ? YES / NO

Do you sleep well ? YES / NO

Do you wake up frequently throughout the night? YES / NO

Do you sleep with a sleeping mask on? YES / NO

Do you sleep with ear plugs in your ears? YES / NO

Do you fatigue easily? YES / NO

Do you snore? YES / NO

Do you have trouble breathing when you sleep? YES / NO

Do you wear a sleep-apnea device? YES / NO

**OTHER PERTINENT MEDICAL ISSUES**

Please write in any other pertinent information that may not have been covered in the above areas:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**AUTHORIZATION:** I hereby authorize Dr. O’Leary and / or his dental staff to administer, diagnostic tests and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The medical history and information provided is given to the best of my knowledge. I also authorize the doctor and/or dental staff to contact my healthcare providers concerning my treatment as necessary.

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature or Guardian’s Signature Date**