Southwest Iowa Dental Associates

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Amanda Schneider D.D.S.

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PATIENT NAME _____ **Date of Birth**__/__/__

YES / NO Do you take an ANTIBIOTIC PRE-MEDICATION before dental cleanings
WHY?_____

YES / NO Do you take a BLOOD THINNER? (Coumadin, Plavix, Xarelto, Elaquis, other)

YES / NO Have you ever taken any BISPHOPHONATES? (Fosamax, Zometa, other)

YES / NO Female patients: Are you NURSING or PREGNANT now? Due Date: ____/____

YES / NO Do you have Sleep Apnea YES / NO Do you use a CPAP

Please mark your **ALLERGIES**: __ Penicillin __ Sulfa __ Clindamycin __ Codeine
__ None __ Medication: _____ Other: _____

Please mark your current **MEDICAL CONDITIONS:**

__ AIDS / HIV	__ Epilepsy/Seizures	__ Liver Disease
__ A-Fib	__ Glaucoma	__ Pacemaker
__ Artificial Heart Valve	__ Heart Attack: ___/___	__ STD/STI
__ Asthma	__ Heart Condition _____	__Sinus Problems
__ Cancer ___ / ____	__ Heart Defect/Murmur	__ C-Diff _____
__ Cold Sores	__ Heart Infection	__ Stroke: ___/___
__ COPD / Emphysema	__ Hepatitis B/C	__ Thyroid Problem
__ Diabetes - Type I / II	__ High Blood Pressure	__ Tuberculosis-TB
__ Drug Use - past / present	__ Kidney Disease	__ Other: _____

Height _____ **Weight** _____

Please LIST or provide a list of MEDICATIONS: _____

_____ _____ _____ _____

_____ _____ _____ _____

Physician / Specialty Doctors _____

Medical Clinic _____

Pharmacy _____

I acknowledge that I have completed this form with accuracy

SIGNATURE _____ **DATE** __ / __ / _____