James A Miller DMD & Aleks Lyashenko DDS

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Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Physician's Name & Date of Last Medical Exam:

_____

_____

Please check all condtions that apply:

- ☐ Alcohol Use
- ☐ Anxiety
- ☐ Cancer
- ☐ Claustraphobia
- ☐ EPI/anesth reaction
- ☐ Fainting
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Metal Allergy
- ☐ Nitrous aversion
- ☐ Pain Med Reaction
- ☐ Radiation Treatment
- ☐ Schrogrens
- ☐ Taken Bisphosphonate
- ☐ Altzheimers/Dementia
- ☐ Arthritis
- ☐ Cephalexin allergy
- ☐ Clindamycin Allergy
- ☐ Epilepsy/Seizure
- ☐ Fibromyalgia
- ☐ Heart Murmur/MVP
- ☐ High Blood Pressure
- ☐ Latex allergy
- ☐ Lymphodema
- ☐ Metronidizole Allerg
- ☐ NSAID prohibition
- ☐ Penicillin allergy
- ☐ Respiratory Disorder
- ☐ Sinus Problems
- ☐ Taking Birth Control
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Chemo
- ☐ CPAP
- ☐ Erythromycin Allergy
- ☐ Gag Reflex
- ☐ Heart Valve surgery
- ☐ History of drug use
- ☐ Liver Disease
- ☐ Marijuana use
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Sleep Apnea
- ☐ Taking Steroids
- ☐ Angina
- ☐ Asthma
- ☐ Chronic Fatigue
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Hemophilia
- ☐ HIV+/Aids
- ☐ Low Blood Pressure
- ☐ Mental Health Issues
- ☐ Nicotine use
- ☐ Pacemaker
- ☐ Premed Required
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Tuberculosis

Please list any medications you are currently taking:

_____

_____

_____

_____

Any other conditions that we should be aware of:

_____

_____

Any other allergies:

_____

_____

Any other serious illness/major surgeries in last 5 years:

_____

_____

Response Date: _____