Any history of the following:

- ☐ *Pre-Med
- ☐ ADD/ADHD
- ☐ AFIB
- ☐ ALLERGIC - IBUPROFEN
- ☐ ALLERGIC TO ASPIRIN
- ☐ ALLERGIC TO CODIENE
- ☐ ALLERGIC TO KEFLEX
- ☐ ALLERGIC TO LATEX
- ☐ ALLERGIC TO SULFA
- ☐ ALLERGIC TO VICODIN
- ☐ ALLERGIC-PENICILLIN
- ☐ ARTIFICIAL JOINT
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Blind
- ☐ Blood Clots
- ☐ Blood Disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ HIV
- ☐ Head Injuries
- ☐ Hearing Impaird/Deaf
- ☐ Heart Defibrillator
- ☐ Heart Disease
- ☐ Heart Fibrillation
- ☐ Heart Murmur
- ☐ Heart Stent
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Insulin Dependant
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ MitralValveProlapse
- ☐ NONE
- ☐ Orencia
- ☐ Other
- ☐ Pacemaker
- ☐ Parkinsons Disease
- ☐ Pregnant Currently
- ☐ Prolactinoma
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rhinitis
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Smoker
- ☐ Stomach Problems
- ☐ Stroke
- ☐ TMJ
- ☐ Thyroid Disease
- ☐ Vertigo

If "other" selected please explain:

_____

_____

List all medications, dosage, and what the medication is for:
You may also email a list to bethanygeymandds@gmail.com *

_____

_____

Physician's Name and Telephone#: _____

Are you currently under a physician's care? ◯ Yes ◯ No

If "yes" please explain:

_____

_____

Do you or have you used any of the following?

☐ Smoke ☐ Chew tobacco ☐ Soft drinks ☐ Sports drinks ☐ Juice

What is most important to you regarding your dental health? _____

Do you snore? * ◯ Yes ◯ No

Are you tired throughout the day? * ◯ Yes ◯ No

Do you have trouble sleeping? * ◯ Yes ◯ No

Are you interested in straightening or whitening your teeth? * ◯ Yes ◯ No