Robert Lipkowitz
GENERAL • COSMETIC • IMPLANT
DENTISTRY

Your Physician's Name _____ Last Visit _____

	YES	NO
Are You Being Treated for a current or recent illness?	☐	☐
Are You Taking Any Medication?	☐	☐
If So, What Medication? _____		
Are You Taking Blood Thinners?	☐	☐
Are You Allergic to Any Medication?	☐	☐
If So, What Medication? _____		
Do You Require Preventive Antibiotic Prior to Treatment?	☐	☐
Are You Pregnant? _____		

Any History Of:	YES	NO	Medications for Problem
Heart Problems?	☐	☐	
High Blood Pressure?	☐	☐	
Rheumatic Fever?	☐	☐	
Kidney Disease?	☐	☐	
Glaucoma?	☐	☐	
Allergy to Anesthesia?	☐	☐	
Emotional Stress?	☐	☐	
Prolonged Bleeding?	☐	☐	
Asthma?	☐	☐	

	YES	NO	
Epilepsy?	☐	☐	
Arthritis?	☐	☐	
Hepatitis?	☐	☐	
Diabetes?	☐	☐	
Artificial Joints?	☐	☐	
Heart Valve Problems?	☐	☐	
HIV?	☐	☐	
Latex Allergy?	☐	☐	
Psychiatric TX?	☐	☐	
Radiation TX?	☐	☐	
Tobacco Use?	☐	☐	
Seizure Disorder?	☐	☐	
Malignancy?	☐	☐	
Environmental Sensitivities?	☐	☐	

Signature: **Date:**