Dr. George D. Mason, D.D.S., P.C.

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List all major surgeries you've had in the past 5 years.

Please list ALL medications you are CURRENTLY TAKING:

Do you have or have you had any of the following?

- ☐ Heart Disease
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Anemia
- ☐ Tuberculosis or Lung Disease
- ☐ Sinus Trouble
- ☐ Ulcers
- ☐ Smoke or use tobacco
- ☐ Do you take antibiotics before dental treatment
- ☐ Liver Disease/Jaundice
- ☐ Diabetes
- ☐ Dry Mouth
- ☐ Herpes
- ☐ STD/Veneral Disease
- ☐ Tumor or Malignancy
- ☐ Radiation Treatment
- ☐ AIDS
- ☐ Hearing Loss
- ☐ Glaucoma
- ☐ Genetic Disorders
- ☐ Anorexia/Bulimia
- ☐ Persistant Cough
- ☐ Cortisone Treatments
- ☐ Frequent Headaches
- ☐ Thyroid Conditions
- ☐ Respiratory Disease
- ☐ Heart Murmur/Mitral Valve Prolapse
- ☐ Congenital Heart Lesions
- ☐ Abnormal Blood Pressure High/ Low
- ☐ Prolonged Bleeding Disorder
- ☐ Asthma / Breathing Problems
- ☐ Epilepsy/Seisures
- ☐ Implants/Artificial Joints Hip Knee Other
- ☐ Consumed Alcohol within24 hrs
- ☐ Acid reflux
- ☐ Hepatitis Type ___
- ☐ Insulin
- ☐ Mono
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Cancer/Chemotherapy
- ☐ History of Drug Addiction
- ☐ Immune Suppress Disorder
- ☐ Fainting Spells
- ☐ History of Emotional or Nervous Disorders
- ☐ Detached Retina
- ☐ Blood Disease
- ☐ Circulatory Problems
- ☐ Food Allergies
- ☐ Heart Attack/ Surgery
- ☐ Pacemaker
- ☐ Currently Pregnant

OTHER IMPORTANT CONDITIONS NOT LISTED ABOVE _____

Are you ALLERGIC to any of the following?

- ☐ Asprin
- ☐ Sulfa Drugs
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Other (please specify) _____
- ☐ Ibuprofen
- ☐ Penicillin/Antibiotics (be specific)
- ☐ Latex, Metal, Plastics
- ☐ Nitrous Oxide

Signature _____ Date _____