Greg A. Crawford, D.D.S.
4116 East State Blvd. ● Fort Wayne, IN 46815 ● Phone: (260) 482-3759

Patient Name: _____
(please print)

In order to safeguard your health while receiving treatment in our office, we desire to stay informed of the medications you are taking. Please fill out this form with the current medications you are taking. If you have a list you would like us to copy and attach to this form, please let us know and we will be happy to do that.

- **I am not taking any prescription medications.** Check box if true □ and initial _____
- I am taking the following medications:

| Prescription Medication Name | For Treatment of: |
|---|---|
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| | |
| | |

- Are you taking aspirin on a regular basis? □ Yes □ No

- I have had an adverse reaction to, or am allergic to, the following medications:

| Medication Name | Reaction Experienced |
|---|---|
| | |
| | |
| | |

- I have had:

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| □ | □ | Artificial Heart Valve(s) | □ | □ | History of Infectious Endocarditis |
| □ | □ | Artificial Joint Replacement | □ | □ | Congenital Heart Disease |
| □ | □ | Heart Transplant | | | |

Signature_____ Date_____

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Updated on | Updated on | Updated on |
| _____ | _____ | _____ |
| Updated on | Updated on | Updated on |