

Patient's name _____ Date: _____

HEALTH HISTORY

Height _____ Weight _____ Physician _____
 Phone _____

DIRECTIONS: All questions will require a NO answer or a positive response in one word or more. PLEASE FILL IN COMPLETELY

1. Has there been any change in your general health in the past year?	OFFICE USE
2. Have you been examined by a physician within the past year? _____ For what reason?	
3. Are you currently being treated by a physician for a medical problem?	
4. Have you ever been seriously ill?	
5. Is there any condition concerning you health or family's anesthetic history that the doctor should be told?	
6. WOMEN ONLY: Are you pregnant/ nursing/taking birth-control pills?	

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	OFFICE USE	HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	OFFICE USE
1. Rheumatic fever?		20. Asthma?	
2. Damaged or artificial heart valve/ Mitral valve prolapse?		21. Emphysema?	
3. High blood pressure?		22. Fainting spells/dizziness?	
4. Low blood pressure?		23. Often feel exhausted of fatigued/night sweats?	
5. Chest pain(angina) on physical exertion		24. Stroke?	
6. Heart attack(s)/other heart disease?		25. Radiation treatment/chemotherapy?	
7. Irregular heart beat?		26. Numbness/tingling any part of body?	
8. Cardiac pacemaker?		27. Been paralyzed?	
9. Blood disorder such as anemia?		28. Convulsions or epilepsy	
10. Excessive bleeding?		29. Frequent serious headaches?	
11. Ankles swell?		30. Psychiatric treatment?	
12. Short of breath with mild exertion?		31. Tendency to faint?	
13. Bronchitis or persistent cough?		32. Nervous breakdown?	
14. Hepatitis/jaundice or liver disease?		33. Low blood sugar?	
15. Tuberculosis?		34. Arthritis?	
16. Stomach ulcers?		35. Glaucoma?	
17. Are you on dialysis?		36. AIDS/HIV?	
18. Kidney disease?		37. Bruise easily?	
19. Porphyria?		38. Do you have a prosthetic joint?	

39. Hemophilia?		44. Gallbladder trouble?	
40. Sinus problems?		45. Sexually transmitted disease?	
41. Colitis?		46. Habit-forming drugs?	
42. Thrombophlebitis?		47. Have you ever used cocaine?	
43. Diabetes? Type 1 or Type 2?		48. Use alcoholic beverages on regular basis?	

MEDICATION

HAVE YOU TAKEN ANY KIND OF MEDICATION, DRUGS OR PILLS THE PAST 2 YEAR?

1. Anticoagulants (blood thinners)?		5. Tranquilizers?	
2. Nitroglycerin		6. Cortisone or steroids?	
3. Phen-Fen? Dates		7. List of all medications taken last 2 years:	
4. Aspirin on regular basis?			
5. Aredia, Zometa, Fosamax, Actenol, Boniva or any medications for bone?			

ALLERGIES

HAVE YOU HAD AN ALLERIGIC OR UNFAVORABLE REACTION TO ANY MEDICATION?

1. Penicillin?		6. Aspirin?	
2. Sodium pentothal?		7. Codeine or other narcotics?	
3. Demerol?		8. Erythromycin?	
4. Sodium brevital?		9. Latex?	
5. Valium?		10. Others?	

DENTAL HISTORY

1. Unfavorable history to local anesthesia?		5. Have had a general anesthetic for Oral Surgery?	
2. Unfavorable reaction for any dental treatment?		6. Difficulty opening your mouth?	
3. Had injury to face, jaw or neck?		7. Does you jaw "click" or pain?	
4. Do you have regular dental care?		8. Had orthodontic care?	

If you were not referred to our office by a General Dentist, would you like a referral to one?

ACKNOWLEDGMENT

I certify that I have read and understand the above questions. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon or any member of his staff responsible for any errors or omissions that I have made in completing this form.

Signature of patient: _____ Date: _____ Reviewed by: _____
(Parent of Guardian if minor)

PLEASE DO NOT COMPLETE THE AREA BELOW, EXCEPT FOR RETURN VISIT

HEALTH HISTORY UPDATE

RETURNING PATIENTS-----PLEASE REVIEW YOUR HEALTH HISTORY AND UPDATE ANY CHANGES HERE:

Signature of patient: _____ Date: _____ Reviewed by: _____
(Parent of Guardian if minor)