

— HEALTH HISTORY —

To our patients:

Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Are you in good health?.....Height.....Weight.....	YES	NO
Have there been any changes in your general health in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Are you under the care of a physician?..... Date of last visit:.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, for what are you being treat?		
Have you had any illness, operation or been hospitalized in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have unhealed injuries or inflamed areas in or around your mouth, growth or sore spots in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...		Yes	No	NOTES	HAVE YOU HAD OR DO YOU CURRENTLY HAVE...		Yes	No	NOTES
1	Rheumatic fever?				27	Stroke?			
2	Damaged heart valves/ mitral valve prolapse?				28	Thyroid trouble?			
3	Heart murmur?				29	Diabetes?			
4	High blood pressure?				30	Low blood sugar?			
5	Low blood pressure?				31	Kidney trouble?			
6	Chest pain, angina?				32	Are you on dialysis?			
7	Heart attack(s)?				33	Swollen ankles, arthritis, joint disease, or joint replacement?			
8	Irregular heart beat?				34	Stomach ulcers?			
9	Cardiac pacemaker?				35	Contagious diseases?			
10	Heart surgery?				36	Sexually transmitted diseases?			
11	Bronchitis, chronic cough?				37	AIDS or HIV infection?			
12	Asthma?				38	Problems of the immune system?			
13	Hay Fever/Sinus problems?				39	A tumor or growth?			
14	Tuberculosis?				40	Mental health problems?			
15	Emphysema?				41	Removable dental appliances?			
16	Difficulty breathing?				42	Are you on a diet?			
17	Any other lung trouble?				43	Alcoholic beverages?			
18	Do you smoke?				44	Contact lenses?			
19	Blood disorder such as anemia?				45	Eye disease/glaucoma?			
20	Bruise easily?				46	X/Ray treatment/chemotherapy?			
21	Bleeding tendency (abnormal bleed?)				47	Blood transfusion?			
22	Jaundice, hepatitis or liver disease?				48	Pain & clicking of jaws when eating?			
23	Infectious mononucleosis?				49	Malignant Hyperthermia?			
24	Gall bladder trouble?				50	Are you taking any medications for osteoporosis such as Actonel or Fosamax?			
25	Fainting spells?				51	Premedicate prior to dental procedure?			
26	Convulsions, epilepsy?								

MEDICATIONS	YES	NO
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ARE YOU NOW TAKING ANY KIND OF MEDICINE, DRUG OR PILLS FOR ANY PURPOSE?

Anticoagulants? Aspirin?

Tranquilizers?

Cortisone?

Other medications? (Please list)

IS THERE ANY CONDITION CONCERNING YOUR HEALTH OR FAMILY'S ANESTHETIC HISTORY THAT THE DOCTOR SHOULD BE TOLD?

WOMEN:

Is there a possibility that you may be pregnant?

Estimated delivery date:

Are you nursing?

Are you taking birth control pills?

ALLERGIES	YES	NO
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ARE YOU ALLERGIC TO OR HAD A REACTION TO:

Local anesthetics

Penicillin or other antibiotics?

Sulfa drugs?

Barbiturates, sedatives or sleeping pills?

Aspirin?

Iodine?

Codeine or other narcotics?

Other medications?

Allergies other than drug allergies? (Please list)P

I certify that I have read and understand the above. 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 other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient (parent or guardian if minor)