

Medical History

1. Height: _____ Weight: _____ Have you had any recent unexplained **weight loss**? ___yes ___no
2. Date of last **physical examination**: _____ Are you in good general health? ___yes ___no
3. Are you now or have you been under the active care of a **physician** in the last five years? ___yes ___no
If yes, please explain: _____

4. Do you take any **medicines** regularly, including **non-prescription or herbal supplements**? ___yes ___no
If yes please list or provide our office with a list: _____

5. **Neurological Disorders**: Are you subject to fainting, dizziness, epilepsy, hearing loss, or psychiatric, or neurological disorders? ___yes ___no
6. **Cardiovascular Diseases**: Have you ever had any cardiac birth defects, heart trouble, heart attack, heart murmur, coronary artery disease, angina, palpitations, heart surgery, a pacemaker, strokes, rheumatic heart disease, damaged/replaced heart valves, or any other cardiovascular diseases? ___yes ___no
7. **Lung Diseases**: Have you ever had any breathing difficulty such as asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, or any other lung disorder? ___yes ___no
Do you **smoke cigarettes**, cigars, or pipe? Packs per day? ____ Years? ____
___yes ___no
8. **Bleeding Disorders**: Have you ever had anemia, easy bruising, prolonged or profuse bleeding or received any blood transfusions? Do you take **blood thinners**? ___yes ___no
9. **Liver Disorders**: Have you ever had hepatitis, cirrhosis, jaundice, or cancers? ___yes ___no
10. **Allergies**: Are you allergic to any medications such as penicillin, sulfa, or other antibiotics? ___yes ___no
Aspirin, codeine, other pain relievers, local or topical anesthetics, barbiturates, sedatives? ___yes ___no
Latex, iodine, tape or any other non airborne allergens? ___yes ___no
11. **Immune disorders**: Have you ever had problems with your immune system, frequent mouth ulcers or sores, cancers, or night sweats? Are you taking anti-rejections drugs? ___yes ___no
12. **General**: Have you ever had any of the following illnesses or diseases? **If yes please circle.**
Kidney disease, High blood pressure, Low blood pressure, Diabetes, Glaucoma, Thyroid Problems, Arthritis, Stomach Ulcers, Sinus Problems, Shortness of Breath, Swollen Ankles, Organ Transplants, Head or Neck Tumor Irradiation, or Artificial Joint Replacement? ___yes ___no
13. Do you have any problems with your **jaw joints** such as limited opening, jaw joint noises, or an inability to close your jaw? ___yes ___no
14. Have you ever had any serious problems associated with any **previous dental treatment**? ___yes ___no
If so, please explain: _____

15. Do you have any **other medical or dental condition** that needs to be discussed? ___yes ___no
16. Do you wish to **speak privately** with the doctor about anything? ___yes ___no
17. **Women Only**: a. Are you pregnant? ___yes ___no
b. Are you nursing? ___yes ___no
c. Are you using birth control medications? ___yes ___no
d. Would you prefer to have a pregnancy test prior to IV anesthesia? ___yes ___no

Main Reason for this Oral Surgery visit: _____

I understand the importance of a truthful and complete health history to assist the doctor in providing the best care. I will not hold the doctor or his staff responsible for any errors of omission that may have been made on this form.

Signed: _____ Date: _____ Signed: _____ Date: _____
Revised

Signed: _____ Date: _____ Signed: _____ Date: _____
Revised

