

Patient Medical History

Patient's Name: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

The following medical information is for your general welfare, whether you are here for diagnostic consultation, a simple extraction, or a major oral surgical procedure. Your general health may have a significant affect on your current condition and on the outcome of any proposed treatment. For the sake of your overall health and safety, please answer **all** questions.

Please circle Yes or No and explain where necessary.

Yes / No Are you seeing a specialist now (cardiologist/hematologist, etc.)? _____

Yes / No Are you under the active care of a physician for any reason? _____

Yes / No When was your last physical examination. Was anything unusual or abnormal found? _____

Yes / No Are there any other medical conditions we should be aware of? _____

Yes / No Are you currently or have you ever taken any medication for osteoporosis? If Yes:
Name of Medication: _____ How long were you on it: _____ Last dose: _____

Yes / No Are you taking diet pills at this time? _____

Yes / No Have you ever taken any of following diet pills?
_____ Fen-Phen (fenfluramine & phentermine) _____ Pondimin (fenfluramine) _____ Redux (dexfenfluramine)

Yes / No If you have ever taken any of the above drugs, have you had a medical examination to insure that your heart valves were not affected? _____

Yes / No Do you have a cough or cold at this time? _____

Yes / No Do you use tobacco products? Type _____ Usage _____

Yes / No Do you drink alcoholic beverages? Usage _____

Yes / No Personal or family history of problems with anesthesia including malignant hyperthermia (MH)? _____

General Dentist Name: _____ Phone Number: _____

Medical Doctor's Name: _____ Phone Number: _____

Pharmacy Name: _____ Phone Number: _____

Women Only

Yes / No Pregnant/Trying to get pregnant? **Yes / No** Taking oral contraceptives? **Yes / No** Nursing?

Do you have, or have you ever had any of the following? Please mark all that apply.

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Murmur/Abnormal Heart Sound | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anxiety/Depression/ Psychiatric Illness Requiring Treatment by a Psychiatrist/ Psychologist |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Painful Joints | Have you ever had allergies to: |
| <input type="checkbox"/> Rheumatic Fever/Rheumatic Heart Disease | <input type="checkbox"/> Pain In Chest | <input type="checkbox"/> Any Foods: _____ |
| <input type="checkbox"/> Heart Disease/Heart Attack | <input type="checkbox"/> Pain In Arms | _____ |
| <input type="checkbox"/> Lung Trouble/TB/+PPD | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Asthma/Bronchitis/Pneumonia | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Swelling of Ankles | <input type="checkbox"/> Snoring/Sleep Apnea | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Anemia/Sickle Cell Disease | <input type="checkbox"/> A.C.T.H./Steroids | <input type="checkbox"/> Demerol |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Blood Transfusion/ Told you cannot donate blood? | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Anesthetics (such as Novocain, etc.) |
| <input type="checkbox"/> Bleeding Problems/Bleed or Bruise Easily | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Cerebrovascular Disease (Stroke/TIA) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other Drugs: _____ |
| <input type="checkbox"/> Prosthetic Joint Surgery (Artificial) | <input type="checkbox"/> Immune System Compromise/ Frequent Infections | _____ |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Tumor/Cancer/Radiation Treatment/ Chemotherapy | |
| <input type="checkbox"/> Jaundice or Liver Disease/Hepatitis | | |
| <input type="checkbox"/> Sinus Problems | | |
| <input type="checkbox"/> Convulsions/Seizures/Epilepsy | | |

Please complete back side of form

Patient's Name: _____

Please list current medications, including over the counter medication and supplements.

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Please list all surgeries: _____

I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. I certify that the information provided here is accurate and complete and that I will ask questions of my doctor and assisting staff to clarify any items I do not understand.

Signature (patients that are 18 years and older must sign this form. The signature of a parent, guardian or spouse is not acceptable)

Date: _____

Relationship to Patient: _____

DOCTOR'S REVIEW

Doctor signature

Date

MEDICAL HISTORY UPDATE (to be filled out at follow-up appointment)

Yes / No Has there been any changes in your health since you last reviewed this form? _____

Yes / No Are you on or taking any new medications? _____

Doctor signature

Date

Notes (office staff only):