MEDICAL HISTORY

PLEASE COMPLETE ALL SECTIONS OF THIS FORM. (ATTACH DETAILS ON A SEPARATE PAGE IF NECESSARY.)

NAME: LAST_____ FIRST_____ MI _____

DATE OF BIRTH:_____ M / F HEIGHT: _____ WEIGHT: _____

EMAIL: _____ CELL PHONE: _____

ADDRESS: STREET_____ CITY_____ STATE _____ ZIP CODE _____

OCCUPATION: _____ SINGLE _____ MARRIED _____

NAME OF SPOUSE OR CLOSEST RELATIVE: _____ PHONE: _____

IF YOU ARE NOT THE PATIENT, WHAT IS YOUR NAME AND RELATIONSHIP TO THE PATIENT? _____

FOR THE FOLLOWING QUESTIONS, CIRCLE YES OR NO. YOUR ANSWERS ARE CONFIDENTIAL AND FOR OUR RECORDS ONLY. YOU MAY BE ASKED QUESTIONS ABOUT YOUR RESPONSES TO THIS QUESTIONAIRE AND THE ANESTHESIOLOGISTS MAY HAVE ADDITIONAL QUESTIONS CONCERNING YOUR HEALTH.

1. ARE YOU IN GOOD HEALTH?_____YES / NO
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE LAST YEAR?_____YES / NO
3. MY LAST PHYSICAL EXAMINATION WAS ON _____
4. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN?_____YES / NO
   A. IF SO, WHAT IS THE CONDITION BEING TREATED? _____
   B. DO YOU HAVE ANY CONDITIONS WE SHOULD BE AWARE OF? (CEREBRAL PALSY, AUTISM, ETC...) _____
5. YOUR PHYSICIAN(S):
   NAME: _____ CITY: _____ PHONE: _____ FAX: _____
   NAME: _____ CITY: _____ PHONE: _____ FAX: _____
6. NAME: _____ CITY: _____ PHONE: _____ FAX: _____
7. HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION OR BEEN HOSPITALIZED WITHIN THE LAST 5 YEARS? YES / NO
   A. IF SO, WHAT WAS THE ILLNESS OR CONCERN? _____
8. DO YOU/HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR CONCERNS?
   A. DAMAGED OR ARTIFICIAL HEART VALVES INCLUDING HEART MURMUR, IRREGULAR RYTHYM OR RHEUMATIC HEART DISEASE?_____YES / NO
   B. CARDIOVASCULAR DISEASE:
      1. HEART FAILURE_____YES / NO
      2. HEART ATTACK_____YES / NO
      3. ANGINA_____YES / NO
      4. CORONARY ARTERY DISEASE_____YES / NO
      5. INBORN HEART DEFECTS_____YES / NO
      6. CARDIAC PACEMAKER_____YES / NO
      7. DO YOUR ANKLES SWELL?_____YES / NO
      8. HIGH BLOOD PRESSURE_____YES / NO
      9. ARTERIOSCLEROSIS_____YES / NO
      10. STROKE_____YES / NO
      11. DO YOU HAVE CHEST PAIN UPON EXERTION?_____YES / NO
      12. CONGENITAL HEART DISEASE_____YES / NO
      13. SHORTNESS OF BREATH AFTER EXERCISE OR WHEN LYING DOWN_YES / NO
   C. ALLERGIES (SEASONAL, ENVIRONMENTAL, HAY FEVER)_____YES / NO
   D. SINUS TROUBLE_____YES / NO
   E. ASTHMA_____YES / NO
   F. FAINTING SPELLS OR SEIZURES_____YES / NO
   G. PERSISTENT DIARRHEA OR WEIGHT LOSS_____YES / NO
   H. DIABETES_____YES / NO
   I. HEPATITIS, JAUNDICE OR LIVER DISEASE_____YES / NO
   J. AIDS OR HIV INFECTION_____YES / NO
   K. THYROID PROBLEMS_____YES / NO
   L. RESPIRATORY PROBLEMS (EMPHYSEMA, BRONCHITIS, ETC...)_____YES / NO
   M. ARTHRITIS OR PAINFUL/SWOLLEN JOINTS_____YES / NO

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N. STOMACH ULCER OR HYPERACIDITY _____ YES / NO

O. KIDNEY TROUBLE _____ YES / NO

P. TUBERCULOSIS _____ YES / NO

Q. PERSISTENT COUGH / COUGH THAT PRODUCES BLOOD _____ YES / NO

R. PERSISTENT SWOLLEN GLANDS IN NECK _____ YES / NO

S. LOW BLOOD PRESSURE _____ YES / NO

T. SEXUALLY TRANSMITTED DISEASE _____ YES / NO

U. EPILEPSY OR OTHER NEUROLOGICAL DISEASE _____ YES / NO

V. PROBLEMS WITH MENTAL HEALTH _____ YES / NO

W. CANCER _____ YES / NO

X. PROBLEMS WITH THE IMMUNE SYSTEM _____ YES / NO

Y. PRIOR CIGARETTE SMOKER? YES / NO CURRENT CIGARETTE SMOKER? YES / NO

Z. DO YOU HAVE SLEEP APNEA? _____ YES / NO

9. HAVE YOU HAD ABNORMAL BLEEDING? _____ YES / NO

A. HAVE YOU REQUIRED A BLOOD TRANSFUSION? _____ YES / NO

10. DO YOU HAVE ANY BLOOD DISORDERS SUCH AS ANEMIA? _____ YES / NO

11. HAVE YOU EVER HAD TREATMENT FOR A TUMOR OR GROWTH? _____ YES / NO

12. ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

A. LOCAL ANESTHETICS _____ YES / NO

B. PENICILLIN OR OTHER ANTIBIOTICS _____ YES / NO

C. SULFA DRUGS _____ YES / NO

D. BARBITUATES, SEDATIVES OR SLEEPING PILLS _____ YES / NO

E. ASPIRIN _____ YES / NO

F. IODINE _____ YES / NO

G. CODEINE OR OTHER NARCOTICS _____ YES / NO

H. OTHER _____

13. HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT OR ANESTHESIA INCLUDING NAUSEA, VOMITING OR MALIGNANT HYPERTHERMIA? _____ YES / NO

IF SO, PLEASE EXPLAIN _____

14. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED THAT YOU THINK YOUR ANESTHESIOLOGIST SHOULD KNOW ABOUT? _____ YES / NO

IF SO, PLEASE EXPLAIN _____

15. ARE YOU WEARING CONTACT LENSES? _____ YES / NO

16. ARE YOU WEARING REMOVABLE DENTAL APPLIANCES? _____ YES / NO

WOMEN

17. ARE YOU PREGNANT? _____ YES / NO

18. DO YOU HAVE ANY PROBLEMS ASSOSIATED WITH YOUR MENSTRUAL PERIOD? _____ YES / NO

19. ARE YOU NURSING? _____ YES / NO

20. ARE YOU TAKING BIRTH CONTROL PILLS? _____ YES / NO

PLEASE LIST ALL CURRENT MEDICATIONS BELOW

_____

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 DENTIST OR THE DENTAL STAFF RESPOSIBLE FOR ANY ERRORS OR OMISSIONS I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

_____ DATE

_____ (NON-ELECTRONIC) SIGNATURE OF PATIENT OR LEGAL GUARDIAN