First name: _____ Last name: _____ BP_____

Age_____ Pulse_____

Area_____

Medical History

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with oral surgery. Thank You for taking the time to answer the following questions.

Are you under a physician's care now?	○ Yes	○ No	If yes, who is your doctor? _____
Have you ever been hospitalized or had any operations?	○ Yes	○ No	If yes, why were you hospitalized or operated? _____
Have you ever had a serious head or neck injury?	○ Yes	○ No	If yes, when and why? _____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	If yes, when? _____
Are you on a special diet?	○ Yes	○ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	○ Yes	○ No	If yes, please list the medications: _____

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following? ○ Yes ○ NO
○ Aspirin ○ Penicillin ○ Codeine ○ Eggs/Soy ○ Metal ○ Latex ○ Local Anesthetics ○ Sulfa-drugs ○ Other: _____

Do you have, or have had, any of the following? Please circle ALL that apply

Heart Problems	Cortisone Medicine	Hepatitis B or C	Scarlet Fever
Lung Problems	Diabetes	Herpes	Shingles
Breathing Problems	Drug Addiction	Hemophilia	Sickle Cell Disease
Bleeding problems	Easily Winded	High Blood Pressure	Sinus Trouble
AIDS/HIV Positive	Emphysema	Hives or Rash	Spina Bifida
Alzheimer's Disease	Epilepsy or Seizures	Hypoglycemia	Stomach/Intestinal
Anaphylaxis	Excessive Bleeding	Irregular Heartbeat	Disease
Anemia	Excessive Thirst	Kidney Problems	Stroke
Arthritis/Gout	Fainting Spells/Dizziness	Leukemia	Swelling of Limbs
Artificial Heart Valve	Frequent Cough	Liver Disease	Thyroid Disease
Artificial Joint	Frequent Diarrhea	Low Blood Pressure	Tonsillitis
Asthma	Frequent Headaches	Lung Disease	Tuberculosis
Blood Disease	Genital Herpes	Mitral Valve Prolapse	Tumors or Growths
Blood Transfusion	Glaucoma	Pain in Jaw Joints	Ulcers
Bruise Easily	Hay Fever	Parathyroid Disease	Venereal Disease
Cancer	Heart Attack/Failure	Psychiatric Care	Yellow Jaundice
Chemotherapy	Heart Murmur	Radiation Treatments	
Chest Pains	Heart Pace Maker	Recent Weight Loss	
Cold Sores/Fever Blisters	Heart Trouble/Disease	Renal Dialysis	
Congenital Heart Disorder	Hemophilia	Rheumatic Fever	
Convulsions	Hepatitis A	Rheumatism	

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, what illness: _____

Have you ever had sleep apnea or do you snore when you sleep? ○ Yes ○ No If yes, please explain: _____

Have you ever had head or neck radiation? ○ Yes ○ NO If yes, when and how many treatments: _____

Have you ever had bisphosphonate therapy (FOSAMAX, AREDIA, ZOMETA) or medications to strengthen your bones? ○ Yes ○ NO

Do you smoke? ○ Yes ○ No If yes how many packs per day? _____

Do you consume alcohol? ○ Yes ○ NO If yes, how many per day/week or month?
_____

Have you ever used any Recreational Drugs? ○ Yes ○ NO If yes, which ones?
_____

Comments:
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____**DATE**_____