HEALTH HISTORY

Please return all forms to your DENTIST'S OFFICE

Name ______________________________ Address ____________________________________
Mr. Mrs. Ms. Dr. Last First Number & Street

City_______________ State ____ Zip ______ Home# _____________ Business# _______________

Date of Birth __________ Age ____ Sex ____ Height ____ Weight lbs. ____ Occupation _____________

Please Circle
Social Security No. _____________ Marital Status: S, M, D, W Name of Spouse: ___________________

Name of Closest Relative ___________________ Relationship: _________ Phone# _________________

Date of Treatment: ______________________ Treating Dentist Name: ___________________________

Planned Procedure: ____

If you are completing this form for another person, what is your relationship to that person? ___________

How do you feel about your procedure? Not at all anxious, anxious, very anxious, extremely anxious.
How do you feel about anesthesia? Not at all anxious, anxious, very anxious, extremely anxious.

For the following questions, circle YES or NO whichever applies. Your answers will remain strictly confidential.

1. Are you in good health? YES NO
2. Has there been any change in your general health or weight within the past year? YES NO
3. My last complete physical was on ____
4. Are you now under the care of a physician? YES NO
   If so, what is the condition being treated? ____
5. The name and address of my physician is __________________________ Phone# _______________
6. Have you had any illness or operation that required hospitalization? YES NO
   If so, what was the illness or operation? ____
7. Do you have or have you had any of the following diseases or problems? ***PLEASE CIRCLE***
   a. Damaged heart valves, artificial heart valves (grafts), knee or hip replacement? YES NO
   b. Congenital heart defect(s) or murmur? YES NO
   c. Cardiovascular disease: heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, or hypertension (high blood pressure)? ***PLEASE CIRCLE*** YES NO
      I Do you have chest pain upon exertion? YES NO
      II Are you ever short of breath after mild exercise? YES NO
      III Do your ankles swell? YES NO
      IV Do you get short of breath when you lie down, or do you require extra pillows when you sleep? YES NO
      V Do you have a cardiac pacemaker? YES NO
      VI Do you have an arrhythmia or an irregular heart beat? YES NO
   d. Has your **physician** ever told you to take antibiotics prior to dental therapy for a medical condition? YES NO
      If yes, why? ____
   e. Sinus trouble? YES NO
   f. Asthma, hay fever, hives, or skin rash? ***PLEASE CIRCLE*** YES NO
   g. Seizures, epilepsy, stroke, or fainting spells? YES NO
      If yes, state cause. ____
   h. Diabetes? YES NO
   i. Is your mouth frequently dry or do you urinate more than six times per day? YES NO
   j. Hepatitis, jaundice or liver disease? YES NO
   k. Have you ever been told not to donate blood? YES NO
      If yes, why? ____
   l. A.I.D.S., A.R.C., or tested positive for HIV? YES NO
   m. Arthritis or inflammatory rheumatism? YES NO
   n. Stomach ulcers? YES NO
   o. Kidney trouble? YES NO
   p. Tuberculosis or a persistent cough or cough up blood? YES NO
   q. Low blood pressure? YES NO
   r. Have you ever had venereal disease? YES NO
   s. Have you ever had a nervous breakdown or psychotherapy? YES NO
   t. Do you have a history of alcoholism or drug dependency? YES NO
   u. Other: ____

8. Have you taken any "recreational" drugs in the past year such as cocaine, crack, marijuana, LSD…etc? YES NO
If so, what? ________________________________ How long ago? ______________________________
9. How much do you smoke a day? ____________________ For how many years? ____________________
10. How much alcohol do you drink per day averaged over the week? ________________________________
11. Do you bleed easily, bruise easily, or have you had abnormal bleeding with previous surgery or dental extractions? YES NO
12. Do you have any blood disorder such as anemia? YES NO
13. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck? YES NO
14. Are you taking any of the following?

	Circle YES or NO	**Drug**	**Dose**	**Reason?**
Antibiotics or sulfa drugs	YES NO			
Anticoagulants (Blood Thinners)	YES NO			
Medicine for high blood pressure (hypertension)	YES NO			
Cortisone or Prednisolone (steroids)	YES NO			
Tranquilizers / Antidepressants / Diet Pills	YES NO			
Antihistamines	YES NO			
Aspirin or Ibuprofen	YES NO			
Insulin, Gliburide or similar drug	YES NO			
Digitalis or drugs for heart trouble	YES NO			
Viagra or Nitroglycerin or other nitrates	YES NO			
Oral contraceptive or other hormonal therapy	YES NO			
Any other prescription or non-prescription meds	YES NO			

15. Are you **allergic** or have you reacted adversely to: ***Please circle drug, State what happens when used.*** ***Please circle***
Local or general anesthetics (which one?) YES NO
Penicillin, Sulfa drugs or other antibiotics. YES NO
Barbiturates, sedatives, Valium, Demerol, codeine or sleeping pills (which one?) YES NO
Aspirin, Advil, or Ibuprofen YES NO
Soy food products, egg products or Iodine YES NO
Latex or Plastic Tape YES NO
Other: ____
16. To the best of your knowledge, has any blood relative had a bad reaction to any anesthetic? YES NO
17. Have you ever had any trouble associated with any previous surgery or anesthetic? YES NO
If so, what? ____
18. Do you have any disease, condition or problem not mentioned above? YES NO
If so, what? ____

WOMEN

Are you pregnant? YES NO
Are you a nursing mother? YES NO
Do you have any problems associated with your menstrual period? YES NO

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore I have reviewed this history carefully and have answered all questions truthfully and to the best of my knowledge.

SIGNATURE OF PATIENT (OR GUARDIAN) **DATE**

FOR DOCTOR'S USE ONLY

HISTORY REVIEWED ☐ ADDITIONAL COMMENTS: NONE ☐ OTHER______________________________________

AIRWAY: MOF______FB, + - UVULA, + - NECK FROM, TMD> ________ cm, + - TMJ MOBILITY, NORMAL PEDIATRIC AIRWAY ☐

HEART: S1-S2 RRR, - MURMUR – S3, - S4 ☐ OTHER ______________________________

LUNGS: CLEAR BILATERAL BREATH SOUNDS ☐ OTHER ______________________________
ASSESSMENT and **PLAN:** ASA: I II III ________ year old M F for ______________________________
______________________________ Under TIVA GA MAC, pre-med with ____________________

Risks and alternatives explained to Pt., questions answered. ☐ Ride arranged with: spouse ☐ parent ☐ other ______________

REVIEWED AND EXAMINED BY: ______________________________ **DATE:** ________________