PATIENT HEALTH HISTORY

Are you in good health? Yes No   Are you currently under the care of a medical doctor? Yes No

If you are currently under the care of a medical doctor. what is your condition or illness?____________________

When were you last examined by a medical doctor?____________________

Do you wear contact lenses? Yes No

Do you smoke? Yes No   If yes how much?________________

Are you currently using IV or recreation drugs? Yes No

Have you ever been a user of IV or recreation drugs? Yes No

Do you drink alcohol? Yes No   If yes, how much, how often. and when?____________________

Are you allergic to any drugs/medications? Yes No

If yes, please specify which drugs/medications you are allergic to:____________________

Are you taking any medications/drugs at present? Yes No

If yes. please list them:____

Have you ever taken any intravenous or oral bisphosphonates to include Boniva, Actonel, or Fosamax? Yes No

What operations/surgeries have you had since birth?____________________________

Have you ever had local anesthesia (novocaine)? Yes No

Have you ever been put to sleep for an operation? Yes No

Have you or anyone in your family ever had a problem with anesthesia? Yes No

If so, please specify:____

Weight:____________   Height:____________

Please describe any other medical problem or condition which might affect your treatment in this office:____________

____

FOR WOMEN ONLY:

*Are you pregnant? Yes No   If yes, how many months?*____________

*When was your last menstrual period?*____________

Are you currently breast-feeding? Yes No

*How many children do you have?*____________   *Are you trying to become pregnant? Yes No*

Do you understand that antibiotics which might be prescribed for you may interfere with the function of the birth control pill? In other words, an antibiotic may make the pill ineffective in preventing pregnancy? Yes No

Do you understand the potential for serious adverse consequences from surgery and/or anesthesia during pregnancy, to include harm to the fetus? Yes No

Is there anything you would like to discuss in private with your oral surgeon? Yes No

Do you wish to consult with your physician to rule out pregnancy before oral surgery? Yes No

(please turn to other side...)

PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR CURRENTLY HAVE:

- ☐ Circulatory Problems (Stroke)
- ☐ TMJ/Jaw Joint Clicking, Locking, or Pain
- ☐ Heart Murmur or Mitral Valve Prolapse
- ☐ Asthma, Lung Disease or Emphysema
- ☐ Ulcers, Colitis or Diverticulitis
- ☐ Kidney Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Radiation Therapy or Chemotherapy
- ☐ Thyroid or Glandular Disease
- ☐ Seizure Disorder (Epilepsy)
- ☐ Glaucoma
- ☐ Blood Transfusions
- ☐ Cancer
- ☐ Candidiasis (Fungal Infections)
- ☐ Viral Infections such as Herpes or AIDS
- ☐ Positive Test for HIV or AIDS virus
- ☐ Bleeding Disorder or Anemia
- ☐ Psychiatric/Mental Disorders
- ☐ Liver Disease
- ☐ High Blood Pressure
- ☐ Hepatitis, Mononucleosis, or Jaundice
- ☐ Artificial/Prosthetic Heart Valve
- ☐ Bone or Joint Disease (Arthritis or Osteoporosis)
- ☐ Diabetes (High Blood Sugar)
- ☐ Heart Disease/Angina/Chest Pains
- ☐ Bone or Joint Replacements
- ☐ Vascular Grafts
- ☐ Tuberculosis

THANK YOU FOR CHOOSING CONCORD ORAL SURGERY P.A.. WE ARE COMMITTED TO CARING FOR YOUR NEEDS.

______________________________ SIGNATURE OF PATIENT ______________________ DATE

______________________________ SIGNATURE OF PARENT/LEGAL GUARDIAN (if patient is under 18) ______________________ DATE

______________________________ SIGNATURE OF DOCTOR ______________________ DATE

FOR OFFICE USE ONLY	FOR OFFICE USE ONLY
ASA______________	BMI______________