ASSOCIATES IN ORAL SURGERY & DENTAL IMPLANTS
MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) or NO (N)

all answers are kept confidential

1.ARE YOU ALLERGIC OR HAVE YOU HAD A BAD REACTION TO:

A.GENERAL ANESTHESIA, SEDATIVES, OR LOCAL ANESTHETICS Y N

B.PENICILLIN, AMOXICILLIN, CEPHALOSPORIN OR OTHER ANTIBIOTICS Y N

C.ASPIRIN OR IBUPROFEN Y N

D.CODEINE OR OTHER PAIN MEDICATIONS Y N

E.LATEX Y N

F.OTHER ALLERGIES OR REACTIONS Y N

PLEASE LIST:_____

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2.LIST ALL OPERATIONS AND HOSPITALIZATIONS_____

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3.DO YOU HAVE OR HAVE YOU HAD:

A.JAW PAIN OR POPPING Y N

B.STROKE Y N

C.SLEEP APNEA Y N

D.CONGENTIAL HEART DISEASE, HEART MURMER, RHEUMATIC HEART DISEASE,HEART SURGERY,CHEST PAIN, ANGINA, HEART ATTACK, PALPATIONS,HIGH BLOOD PRESSURE Y N

E.LUNG DISEASE: ASTHMA, EMPHYSEMA, BRONCHITIS, PNEUMONIA OR TUBERCULOSIS Y N

F.SEIZURES, EPILEPSY, MENTAL RETARDATION, PSYCHIATRIC TREATMENT OR ALZHEIMERS Y N

G.BLEEDING DISORDER, BLEEDING TENDENCY, BLOOD TRANSFUSION OR ANEMIA Y N

H.LIVER DISEASE: JAUNDICE, HEPATITIS Y N

I.KIDNEY DISEASE Y N

J.DIABETES Y N

K.THYROID DISEASE (GOITER) Y N

L.ARTHRITIS Y N

M.OSTEOPOROSIS Y N

N.REFLUX, STOMACH ULCERS OR COLOITIS Y N

O.GLAUCOMA Y N

P.SINUS OR NASAL PROBLEMS OR ALLERGIES Y N

Q.CANCER Y N

R.RADIATION (X-RAY) TREATMENT FOR CANCER Y N

S.IMPLANTS PLACED ANYWHERE IN YOUR BODY (HEART VALVE/HIP OR KNEE REPLACEMENT) Y N

T.ANY DISEASE, DRUGS OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM Y N

U.ANY OTHER DISEASE OR DISORDER NOT LISTED ABOVE PLEASE LIST:

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_____

4.ARE YOU USING OR TAKING ANY OF THE FOLLOWING:

A. ANTIBIOTICS Y N

B.ANTICOAGULANTS (BLOOD THINNERS) Y N

C.HIGH BLOOD PRESSURE OR HEART MEDICINE Y N

D.STEROIDS (CORTISONE,ETC) Y N

E.INSULIN OR ORAL MEDICATION FOR DIABETES Y N

F.BISPHOSPONATES FOR OSTEOPOROSIS OR CANCER (CURRENTLY OR IN PAST) FOSAMAX, ACTONEL BONIVA, RECLAST, AREDIA, ZOMETA Y N

G.ASPIRIN OR NSAID (IBUPROFEN, MOTRIN, ADVIL, ALEVE, ETC) Y N

H.MARIJUANA OR OTHER "STREET DRUGS" Y N

I. LIST ALL MEDICATION YOU TAKE:_____

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5.DO YOU SMOKE,CHEW OR DIP TOBACCO Y N

6.DO YOU HAVE OR HAVE YOU HAD AN ALCOHOL OR DRUG DEPENDENCE Y N

7.FOR WOMEN ONLY

A.IF YOU ARE USING ORAL CONTRECPTIVES, IT IS IMPORTANT THAT YOU UNDERSTAND THAT ANTIBIOTICS AND OTHER MEDICATIONS MAY INTERFERE WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES, THEREFORE YOU WILL NEED TO USE MECHANICAL FORMS OF BIRTH CONTROL FOR ONE COMPLETE CYCLE OF BIRTH CONTROL PILLS AFTER THE COURSE OF ANTIBIOTICS OR OTHER MEDICATIONS IS COMPLETED.PLEASE CONTACT YOUR PHYSICIAN FOR FUTHER GUIDANCE.

B.IF YOU ARE PREGNANT, POSSIBLY PREGNANT OR TRYING TO BECOME PREGNANT, ANESTHESIA AND OTHER MEDICATIONS MAY SIGNIFICANTLY HARM YOUR DEVELOPING BABY, ESPECIALLY DURING THE FIRST TRIMESTER. **PLEASE ADVICE YOUR DOCTOR IF THERE IS ANY CHANCE OF YOUR BEING PREGNANT!**

C. ARE YOU PREGNANT? Y N

D.ARE YOU NURSING? Y N

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I UNDERSTAND THE IMPORTANTCE OF AN ACCURATE HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE.

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY DATE DOCTORS INITIALS