Medical History **Atlantic Oral Surgery**

Patient Name: _____ Date of Birth: _____ Date: _____

Answer all questions by circling Yes or No: **All responses are kept confidential**

1. Are you in good health? Yes No
2. Has there been any change in your general health? Yes No
3. Date of last physical exam
4. Are you now under a physician's care for a particular problem? Yes No
5. Have you had any serious illnesses, operations or hospitalizations? Describe: _____ Yes No
6. Height _____ Weight _____

7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - Rheumatic Fever or Heart Disease? Yes No
   - Congenital Heart Disease? Yes No
   - Cardiovascular Disease *(Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)*? Yes No
   - Lung Disease *(Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain)*? Yes No
   - Seizures, Convulsions, Epilepsy, Fainting or Dizziness? Yes No
   - Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? Yes No
   - Liver Disease *(Jaundice, Hepatitis)*? Yes No
   - Kidney Disease? Yes No
   - Diabetes? Yes No
   - Thyroid Disease *(Goiter)*? Yes No
   - Arthritis? Yes No
   - Stomach Ulcers or Colitis? Yes No
   - Glaucoma? Yes No
   - Implants placed anywhere in your body *(Heart Valve, Pacemaker, Hip, Knee)* Yes No
   - Radiation *(X-Ray)* treatment for Cancer? Yes No
   - Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth
   - Sinus or Nasal problems? Yes No
   - Any disease, drug or transplant operation that has depressed your immune system? Yes No

8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - Antibiotics? Yes No
   - Anticoagulants *(Blood Thinners)*? Yes No
   - Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Yes No
   - High Blood Pressure Medicine? Yes No
   - Steroids *(Cortisone, etc.)*? Yes No
   - Tranquilizers? Yes No
   - Insulin or Oral Anti-Diabetic drugs? Yes No
   - Digitalis, Inderal, Nitroglycerin or other heart drug? Yes No
   - Are you taking or have you ever taken Bisphosphonates *(Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.)*? Yes No
   - Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamin or minerals:

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - Local Anesthesia *(Novocain, etc.)*? Yes No
   - Penicillin or other antibiotics? Yes No
   - Sedatives, Barbiturates? Yes No
   - Aspirin or Ibuprofen? Yes No
   - Codeine or other pain killers? Yes No
   - Latex or rubber products? Yes No
   - Other allergies or reactions? Please list below:

10. Do you smoke or chew tobacco? Yes No
    How much per day? _____
11. Is there any past history of alcohol or chemical dependency? Yes No
12. Emotional disorder that may affect the care we provide you? Yes No
13. Have you had any serious problems associated with any previous dental treatment? If yes, explain: Yes No
14. Have you or an immediate family member had any problem associated with intravenous anesthesia? Yes No
15. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No
16. Do you wish to talk to the doctor privately about anything? Yes No

17. **FOR WOMEN ONLY**
    - Are you pregnant, or *<u>is there any chance</u>* you might be pregnant? Yes No
    - Are you nursing? Yes No
    - **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Medical History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Medical History with my doctor.

Date _____ Signature of Person Completing Medical History _____ Doctor's Initials _____

Medical Update: I have read my Medical History dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions or changes	Patient's Signature	Doctor's Initials
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