MEDICAL HISTORY

Name _____ Home phone (____)_____-_____
Last First

Address _____ Business phone (____)_____-_____
Number and Street

City _____ State _____ Zip Code _____

Occupation _____

Date of Birth ____/____/____ Sex M F Height _____ Weight _____

In case of emergency contact _____ Phone _____

Name of Dentist _____

Name of Physician _____ Phone _____

Date of last medical exam ____/____/____

List all medications you are taking (include vitamins, herbs, birth control pills or steroids):

_____

_____

Do you have any allergies? No Yes If yes, to what: _____

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. Are you under the care of a Physician? ..... Yes No
   If yes, for what condition? _____
4. Have you had any serious illness, operation or been hospitalized in the past 5 years? Yes No
   If yes, for what condition? _____
5. Are you taking any medications? Please list above. ..... Yes No
6. Are you using any recreational drugs? Please list. _____ Yes No
7. Do you have or have you had any of the following diseases or problems? ..... Yes No
   a. Damaged or artificial heart valve(s), Heart murmur, Rheumatic Heart Disease? Yes No
   b. Artificial joints or grafts? ..... Yes No
   c. Congenital heart defect(s) or murmur? ..... Yes No
   d. Cardiovascular Disease: Heart Attack, Angina, Coronary disease, High Blood Pressure, Arteriosclerosis, Stroke? ..... Yes No
      1. Can you walk a flight of stairs without stopping to rest? ..... Yes No
      2. Do you get short of breath easily? ..... Yes No
      3. Do your ankles swell during the day? ..... Yes No
      4. Do you have any heart defects or a pacemaker? ..... Yes No
      5. Do you have any arrhythmia or irregular heart rhythm? ..... Yes No
8. Has your physician ever told you to take antibiotics prior to dental visits? ..... Yes No
   If yes, for what condition?_____

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9. Do you have or have you had any of the following? Please circle all that apply.

Asthma	Bronchitis	Pneumonia	Yes	No
Emphysema	Tuberculosis (TB)	Chronic cough	Yes	No
Hay Fever/Allergies	Sinus Congestion	Diabetes	Yes	No
Persistent Diarrhea	Recent weight loss	Hepatitis	Yes	No
Jaundice	Liver disease	AIDS/HIV	Yes	No
Fainting Spells	Seizures/Epilepsy	Thyroid Problems	Yes	No
Arthritis	Painful Joints	Ulcers	Yes	No
Chronic Heartburn	Kidney Trouble	Swollen glands	Yes	No
Low Blood Pressure	High Blood Pressure	Cancer	Yes	No
Psychiatric Problems	Compromised Immune System	Gastric Reflux	Yes	No
Sinusitis	Post Nasal Drip	GERD	Yes	No
Sleep Apnea	Limited Mouth Opening	Stiff neck	Yes	No
Severe "gag" reflex	TMJ Disorder	Frequent Urination	Yes	No

10. Do you currently have a cold, flu, runny nose, cough, congestion of the head or chest?..... Yes No
11. Do you smoke? Packs per day _____ How many years? _____
12. Do you have a history of alcohol use and/or drug use? ..... Yes No
    If yes, what _____ Last use_____
13. Do you have any bleeding disorders? (i.e. Anemia, Sickle Cell, Prolonged Bleeding) .....Yes No
14. Have you had surgery or radiation treatment for a tumor/growth of your head or neck? .....Yes No
15. Have you had general anesthesia for an operation before?.....Yes No
16. Have you had any serious trouble associated with any previous dental treatment, surgery, or any previous anesthetic? If yes, explain _____
    _____
17. Has anyone in your family had an adverse reaction to a previous anesthetic? ..... Yes No
18. Do you snore heavily or have obstructive sleep apnea? ..... Yes No
19. Do you have any condition not already mentioned? ..... Yes No

WOMEN

19. Are you currently pregnant? ..... Yes No
20. Is there any possibility that you may be pregnant? ..... Yes No
21. Are you nursing? ..... Yes No

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

Signature of Patient/Parent/Guardian _____ Date _____

Reviewed by Dr. Laura Matsunaga _____ Date _____