

MEDICAL HISTORY (ALL RESPONSES ARE KEPT CONFIDENTIAL)

REFERRING DENTIST _____ GENERAL DENTIST (if different) _____
MEDICAL DOCTOR _____ HEIGHT _____ WEIGHT _____

Answer all questions by circling YES (Y) or No (N)

1. Have you ever had any adverse effects from dental treatment? Y N
2. Do you wear a denture or removable appliance? Y N
3. Clicking or Popping of the Jaw Joint, Pain Near Ear, Difficulty Opening Mouth, Grind or Clench Teeth?..... Y N
4. Have you or a family member had problems with general anesthesia?.....Y N
5. Do you snore or have you been diagnosed with sleep apnea?.....Y N
6. Do you smoke or chew tobacco? Y N
7. Do you use Marijuana or other "street drugs"? ... Y N
8. Do you use alcohol? Y N
9. Are you pregnant or nursing?.....Y N
If yes, how many months _____

Are you taking any of the following medications:

If yes, please indicate name of medication on next page.

1. Thyroid Medications..... Y N
2. Antibiotics or Sulfa Drugs Y N
3. Anticoagulants (Blood Thinners)..... Y N
4. High blood Pressure Medicine..... Y N
5. Steroids (Cortisone, etc.) Y N
6. Tranquilizers (Valium, etc.)..... Y N
7. Insulin or Anti-Diabetic drug..... Y N
8. Digitalis, Inderal, Nitroglycerin, Calcium Channel Blockers, Procardia, or other Heart Medicine?... Y N
9. Aspirin or Ibuprofen Y N
If so, how much daily _____
10. Antihistamines or Decongestants..... Y N

Are you allergic or had a bad reaction to: If answering yes, please circle condition(s).

1. Local Anesthetic (Novocaine, etc.)..... Y N
2. Penicillin, Amoxicillin, Cephalosporins or other Antibiotics Y N
3. Barbiturates, Sedatives, etc..... Y N
4. Aspirin or Ibuprofen Y N
5. Codeine or other Pain Killers..... Y N
6. Latex or Rubber Products Y N
7. Eggs Y N
8. Soybeans..... Y N
9. Sulfa Y N
9. Other Allergies or Reactions _____ Y N

Do you have or have you ever had: If answering yes, please circle condition(s) that pertains to you.

1. Scarlet or Rheumatic Fever Y N
2. Congenital heart disease Y N
3. Cardiovascular Disease/Heart Condition.....Y N
 - Angina..... Y N
 - Heart murmur..... Y N

- Heart attack: if yes, when _____ Y N
 - Heart surgery: if yes, when _____ Y N
 - High blood pressure..... Y N
 - Low blood pressure..... Y N
 - Pacemaker..... Y N
 - Stroke..... Y N
4. Lung Disease
 - Asthma.....Y N
 - Emphysema.....Y N
 - Bronchitis.....Y N
 - Tuberculosis.....Y N
 - Shortness of breath..... Y N
 - Pneumonia.....Y N
 5. Bleeding Disorder
 - Anemia.....Y N
 - Bleed or bruise easily..... Y N
 6. Nervous Disorder
 - Epilepsy/Seizures..... Y N
 - Fainting Y N
 - Psychiatric treatment..... Y N
 7. Liver Disease (Jaundice, Hepatitis) Y N
 8. Kidney Disease Y N
 9. Diabetes Y N
 10. Thyroid Disease Y N
 11. Arthritis..... Y N
 12. Stomach Ulcers or Colitis..... Y N
 13. Glaucoma..... Y N
 14. Bone disease
 - Medications _____
 15. Treatment for Cancer
 - Surgery..... Y N
 - Radiation..... Y N
 - Chemotherapy..... Y N
 - Oral cancer drugs..... Y N
 16. Immune System Y N
 - HIV/AIDS..... Y N
 17. Have you had an organ or tissue transplant...Y N
 18. Frequent or Recurring Mouth Sores Y N
 19. Implants placed anywhere in your body (Heart Valve, Hip, Knee)..... Y N
 20. Sinus or Nasal Problems? Y N

- Do you have any other disease or condition not listed above that the doctor should know about?.....Y N
If yes, please list _____
- Do you wish to talk to the doctor privately about anything? Y N

For Women Only:

- Antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Please advise the doctor if there is any chance of your being pregnant.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

Date _____

Signature of person completing Health History _____

Doctor's Initials _____

DR. EDWARD B. DELGADO
Diplomat of the American Board of Oral and Maxillofacial Surgery

PLEASE LIST ALL MEDICATIONS BELOW THAT YOU ARE TAKING

MEDICATION	STRENGTH	FREQUENCY

PATIENT SIGNATURE _____

DATE _____