GOLDMAN ORAL SURGERY

PLEASE PRINT NEATLY:

Name: ______________________________ Height ___________ Weight ______ DOB ___/___/___

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Have there been any changes in your general health in the past year? **Yes** **No**
If yes, please describe: ____

Are you now under a physician's care for a particular problem at this time? **Yes** **No**
If yes, why? ___________________________________ Date of last physical exam ____/____

Have you ever been hospitalized or had a serious illness? **Yes** **No**
If yes, explain: ____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)? **Y N**

Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? **Y N**

Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)? **Y N**

Bleeding disorder, anemia, bleeding tendency, blood transfusion? **Y N**

Do you bruise easily? **Y N**

Kidney or Liver disease? **Y N**

Thyroid disease? **Y N**
Diabetes? **Y N**
Stomach ulcers or colitis? **Y N**

Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth? **Y N**

Seizures, convulsions, epilepsy, fainting or dizziness? **Y N**

Frequent or recurring mouth sores? **Y N**
Sinus or nasal problems?

Cancer ? **Y N**

Radiation to the head or neck for cancer treatment? **Y N**

Osteoporosis or osteopenia? **Y N**

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No
Are you nursing? Yes No

MEDICATIONS : LIST ALL
medications you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

__________________ __________________ __________________ ___________________
__________________ __________________ __________________ ___________________
__________________ __________________ __________________ ___________________

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Codeine or other pain killers?	**Y N**	Penicillin or other antibiotics?	**Y N**
Motrin, Aleve, or ibuprofen?	**Y N**	Sedatives, barbiturates?	**Y N**

Other allergies not listed above: ____

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation?
If yes, which anesthetic? _______________ Relationship? __________________

SOCIAL HISTORY

Do you use tobacco? **Y** **N** If yes, for how long? ______________________________

Alcohol? How often? ______________
Marijuana? How often? ______________
Recreational drugs? How often? ______________

Have you ever sought professional care or been hospitalized for:
Drug abuse? **Y N** Emotional disorders? **Y N** Alcoholism? **Y N**

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.

To the best of my knowledge, the above information is complete and correct.

Name of Patient (Print)____

Signature of patient, parent, guardian_______________________________Date _____________

Printed name of patient, parent, guardian/relationship __________________________________

Doctor's Signature ____ Date ____________

UPDATE ____ Date__________