— PATIENT INFORMATION SHEET —

Date: ____________

First Name: ____________ Middle Initial: ______ Last Name: ____________

☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ____________

Sex: ☐ Male ☐ Female Date of Birth: ________ Age: _____ Social Security No.: ____________

Street: ____________ City: ____________ State: ______ Zip: ______

Home Tel.: (_____) ____________ Bus. Tel.: (_____) ____________ Cell #:(_____) ____________

Email: ____________

Nearest relative not living with you (name, address & phone): ____________

____

Physician: ____________ Dentist: ____________

Referred by: ☐ Dentist ☐ Friend ☐ Relative ☐ Internet ☐ Phone Book ☐ Self

Student: ☐ Full Time ☐ Part Time **School/College** ____________

IF PATIENT IS UNDER 18:

Who will be responsible for your account? ☐ Mother ☐ Father Soc.Sec. # ____________

MUST FILL OUT ☐ **Married** ☐ **Divorced** ☐ **Single**

Name: ____________ Home Tel.: (_____) ____________

Street/City/State/Zip: ____________ Date of Birth ____________

Employer: ____________ Tel.: (_____) ____________

— HEALTH HISTORY —

To our patients:

Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Are you in good health? ☐ Yes ☐ No Height ____________ Weight ____________

Have there been any changes in your general health in the past year? ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No Date of last visit ____________

If so, for what are you being treated? ____________

Have you had any illness, **operation** or been hospitalized in the past? ☐ Yes ☐ No

If so, for what and when ____________

Do you have unhealed injuries or inflamed areas in or around your mouth, growth or sore spots in your mouth? ☐ Yes ☐ No

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE . . .	Yes	No	NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE/USE . . .	Yes	No	NOTES
1	Joint replacement?				27	Kidney trouble?			
2	Rheumatic fever?				28	Are you on dialysis?			
3	Jaundice, hepatitis or liver disease?				29	Gallbladder trouble?			
4	Contagious diseases?				30	Fainting spells?			
5	Sexually transmitted diseases?				31	Problems of the immune system?			
6	AIDS or HIV infection?				32	Infectious mononucleosis?			
7	Damaged heart valves/ mitral valve prolapse?				33	Convulsions, epilepsy?			
8	Heart murmur?				34	Swollen ankles, arthritis or joint disease?			
9	High Blood pressure?				35	Stomach ulcers?			
10	Low blood pressure?				36	Stroke?			
11	Chest pain angina?				37	Thyroid trouble?			
12	Heart attack(s)?				38	Diabetes?			
13	Irregular heart beat?				39	Low blood sugar?			
14	Cardiac pacemaker?				40	A tumor or growth?			
15	Heart surgery?				41	Mental health problems?			
16	Bronchitis, chronic cough?				42	Removable dental appliances?			
17	Asthma?				43	Are you on a diet?			
18	Hayfever/Sinus problems?				44	Drugs?			
19	Tuberculosis?				45	Alcohol beverages?			
20	Emphysema?				46	Contact Lenses?			
21	Difficulty breathing?				47	Eye disease/glaucoma?			
22	Any other lung trouble?				48	X-Ray treatment/chemotherapy?			
23	Do you smoke?				49	Blood transfusion?			
24	Blood disorder such as anemia?				50	Pain & clicking of jaws when eating?			
25	Bruise easily?				51	Malignant Hyperthermia?			
26	Bleeding tendency (abnormal bleed?)				52				

MEDICATION	YES	NO
ARE YOU NOW TAKING ANY KIND OF MEDICINE, DRUG OR PILLS FOR ANY PURPOSE?	☐	☐
Blood Thinners?	☐	☐
Tranquilizers?	☐	☐
Cortisone?	☐	☐
Other medications? (Please list) ______________________	☐	☐

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO:	YES	NO
Latex?	☐	☐
Surgical tape or band-aids?	☐	☐
Local Anesthesia?	☐	☐
Penicillin, amoxicillin or any antibiotics? ______________	☐	☐
Codeine or other narcotics? ______________	☐	☐
Aspirin?	☐	☐
Sulfa drugs?	☐	☐
Other medications? ______________ ______________________	☐	☐
IS THERE ANY CONDITION CONCERNING YOUR HEALTH OR FAMILY'S ANESTHETIC HISTORY THAT THE DOCTOR SHOULD BE TOLD?	☐	☐
WOMEN:		
Is there a possibility that you may be pregnant?	☐	☐
Estimated delivery date?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills	☐	☐

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient: ______________________ Date: __________

Operating Dr. ______________________ Date: __________