**Today's Date** **Patient's Name** **Birth Date**

__/__/__ _____ __/__/__

***Name of person completing form (if different from patient) and relation to patient***

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality of care. All information will be kept confidential.

****************PLEASE ANSWER BY CIRCLING Y (Yes) or N (No) FOR EACH INDIVIDUAL QUESTION******************

| | | | |
|---|---|---|---|
| 1. | Are you in good health? | Y | N |
| 2. | Has there been any change in your general health in the past year? | Y | N |
| 3. | Date of last check up by physician: _____ | | |
| 4. | Are you currently under a physician's care? | Y | N |
| | If so, what for? _____ | | |
| | Treating Physician's Name: _____ Phone Number: _____ | | |
| 5. | Have you had a stroke, heart attack, or joint replacement in the last six months? | Y | N |
| | If so, describe and give approximate dates: _____ | | |
| | _____ | | |
| 6. | Have you ever had intravenous sedation or general anesthesia? | Y | N |
| | Were there any adverse effects? | Y | N |
| 7. | Do you generally tolerate dental treatment well? | Y | N |
| 8. | DO YOU HAVE OR HAVE YOU EVER HAD: | | |
| | A. Heart disease that was detected at birth? | Y | N |
| | B. Rheumatic fever or Rheumatic heart disease? | Y | N |
| | C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? | Y | N |
| | D. Lung Disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? | Y | N |
| | E. Neurologic Disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)? | Y | N |
| | F. Blood Disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)? | Y | N |
| | G. Liver Disease (jaundice, hepatitis)? | Y | N |
| | H. Kidney Disease? | Y | N |
| | I. Diabetes? | Y | N |
| | J. Thyroid Disease (hypothyroidism, tumor)? | Y | N |
| | K. Arthritis? (which joints?) _____ | Y | N |
| | L. Stomach ulcers or Intestinal problems? | Y | N |
| | M. Glaucoma? | Y | N |
| | N. Frequent or recurring mouth sores? | Y | N |
| | O. Implants/artificial joints anywhere in your body? (heart valve, hip, knee)? | Y | N |
| | **Date of surgery** _____ **Name & Number of surgeon** _____ | | |
| | P. Radiation (X-Ray treatment for cancer) in head and neck region? | Y | N |
| | Q. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth? | Y | N |
| | R. Sinus or nasal problems? | Y | N |
| | S. Any disease, drug, or transplant operation that has depressed your immune system? | Y | N |
| | T. Recurrent infections of any kind? | Y | N |
| 9. | ARE YOU TAKING OR USING ANY OF THE FOLLOWING: | | |
| | A. Antibiotics? | Y | N |
| | B. Anticoagulants (blood thinners)? | Y | N |
| | C. Thyroid medications? | Y | N |
| | D. Antihistamines, decongestants? | Y | N |
| | E. High blood pressure or heart medication? | Y | N |
| | F. Steroids? | Y | N |
| | G. Tranquilizers, Antidepressants? | Y | N |
| | H. Stomach or GI medications (antacids, etc.)? | Y | N |

→→→**Please continue on other side of form** _____ ⇨

I. Cholesterol reducing drugs? ..... Y N
J. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain relievers? ..... Y N
K. Weight reduction pills or diet aids (over the counter or "natural" products)? ..... Y N
L. Vitamins, natural remedies, (ginko biloba, ephedra, ginseng, etc.) or other supplements? ..... Y N
M. Marijuana, cocaine or other "recreational" drugs? ..... Y N
N. Any other regular medications, pills, supplements or drugs? ..... Y N

**PLEASE LIST ALL CURRENT MEDICATIONS HERE** _____

_____

_____

10. ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:
    A. Local anesthetic (Novocaine-like drugs)? ..... Y N
    B. Penicillin, Amoxicillin, Cephalosporins? ..... Y N
    C. Other antibiotics? ..... Y N
    D. Barbiturates, sedatives? ..... Y N
    E. Aspirin, ibuprofen, NSAIDS, or other pain medicines? ..... Y N
    F. Codeine or other narcotics or opioids? ..... Y N
    G. Latex? ..... Y N
    H. Other allergies or reactions? ..... Y N
    If so, please list: _____
    _____
11. Do you have hay fever, frequent skin rashes, etc.? ..... Y N
12. Do you use alcohol? How much per day? _____ Y N
13. Do you smoke? ..... Y N
    What product and how many per day?_____For how long?_____
14. Do you chew tobacco? .....For how long?_____ Y N
15. Are you, or have you been, in a drug or alcohol recovery program? ..... Y N
16. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?..... Y N
17. Do you wish to talk to the doctor privately about anything? ..... Y N
18. Any additional comments? _____

_____

19. **WOMEN**
    A. Are you taking birth control pills? ..... Y N
    B. Are you pregnant, trying to become pregnant or <u>any chance</u> you might be pregnant? ..... Y N
    C. Are you breast feeding? ..... Y N
    D. Are you taking hormone replacement? ..... Y N

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**I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.**

_____ _____ [ ]

Date Signature of Patient/Guardian Doctor's Initials

**THANK YOU. Please return this form to the receptionist before completing others in this packet; do not write below this line.**

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**Medical Update:** I have reviewed my health history dated ____/____/____and confirm that it accurately states past and present conditions.

**Exceptions:** _____

_____

_____

_____

_____ _____ [ ]

Date Signature of Patient/Guardian Doctor's Initials

Dr. Alberto J Ambard, DDS, MS