DESERT RIDGE IMPLANT & ORAL SURGERY

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Medical History

Patient's Name: _____ Today's Date: _____

Physician Name: _____ Physicians Phone #: (____)_____

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

All Responses are kept confidential

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 physical exam _____
4. Are you now under a physician's care for a particular problem?..... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe…….. Y N
   _____
6. Height_____ Weight_____
7. **DO YOU HAVE OR HAVE EVER HAD:**
   - A. Rheumatic Fever of Rheumatic Heart Disease?..... Y N
   - B. Congenital Heart Disease?..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)?..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Severe Coughing, and/or Difficulty breathing at night)?..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder?..... Y N
   - F. Bleeding Disorder Anemia, Bleeding Tendency, 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 (Goiter)?..... Y N
   - K. Arthritis?..... Y N
   - L. Stomach Ulcers or Colitis?..... Y N
   - M. Glaucoma?..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? …….. Y N
   - O. Radiation (x-ray) treatment for Cancer?..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?..... Y N
   - Q. Sinus or Nasal problems?..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system?..... Y N
   - S. HIV, AIDS or ARC?..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING**?
   - A. Antibiotics?..... Y N
   - B. Anticoagulants (Blood Thinners)?..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications…….. Y N
   - E. Steroids (Cortisone, etc.)?..... Y N
   - F. Tranquilizers?..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs?..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drugs?..... Y N
   - I. Any regular medicine, pills or drugs - either over-the-counter or prescription?..... Y N
     If yes, please list _____
     _____
9. ARE YOU ALLERGIC TO OR HAD AN ADVERSE REACTION TO:
   - A. Local Anesthesia (Novocaine, etc.)?..... Y N
   - B. Penicillin or other antibiotics?..... Y N
   - C. Sedatives, Barbiturates?..... Y N
   - D. Aspirin or Ibuprofen?..... Y N
   - E. Codeine or other pain killers?..... Y N
   - F. Latex or Rubber Products?..... Y N
   - G. Other allergies or reactions?..... Y N
     Please list_____
     _____
     _____
10. Do you smoke or chew tobacco?..... Y N
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?..... Y N
12. Have you had any serious problems associated with any previous dental treatment?..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia?..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?..... Y N
15. Do you wish to talk to the doctor privately about anything?..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant?..... Y N
    - B. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult your physician for further guidance.

I understand the importance of a truthful Medical History to assist the doctor in providing the best possible care. I have had the opportunity to discuss my Medical History with my doctor.

_____ _____ _____

Date Signature of Person Completing Medical History Doctor's Initials