

NAME _____

To Our Patients:

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.

Reason for today's office visit: _____

A. General	Yes	No
1. Are you in good health? Height _____ Weight _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Have there been any changes in your general health in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you under the care of a physician? Date of last visit: _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, for what are you being treated?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had any illness, operation or been hospitalized in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any current diseases or conditions? If so, please list	<input type="checkbox"/>	<input type="checkbox"/>

B.	HAVE YOU HAD OR DO YOU CURRENTLY HAVE	YES	NO	NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE	YES	NO	NOTES
1.	Rheumatic fever					27. Thyroid trouble?			
2.	Damaged heart valves/mitral valve prolapse?					28. Diabetes?			
3.	Heart murmur?					29. Low blood sugar?			
4.	High blood pressure?					30. Kidney trouble?			
5.	Low blood pressure?					31. Swollen ankles, arthritis or joint disease?			
6.	Chest pain, angina?					32. Stomach ulcers?			
7.	Heart attack(s)?					33. Contagious diseases?			
8.	Irregular heart beat?					34. Sexually transmitted diseases?			
9.	Cardiac pacemaker?					35. Problems of the immune system?			
10.	Heart surgery?					36. A tumor or growth?			
11.	Bronchitis, chronic cough?					37. Mental health problems?			
12.	Asthma?					38. Alcoholic beverages (past 24 hrs)?			
13.	Hayfever/Sinus problems?					39. Contact Lenses?			
14.	Tuberculosis?					40. Eye disease/glaucoma?			
15.	Emphysema?					41. X-Ray treatment/chemotherapy?			
16.	Difficulty breathing? Any other lung trouble?					42. Chronic fatigue/Night sweats?			
17.	Blood transfusion?					43. Pain/Clicking of jaws when eating?			
18.	Blood disorder such as anemia?					44. Malignant Hyperthermia?			
19.	Bruise easily?					45. Do you smoke?			
20.	Bleeding tendency (abnormal bleed?)					46. Are you on dialysis?			
21.	Jaundice, hepatitis, liver disease?					47. Are you wearing a removable dental appliance?			
22.	Infectious mononucleosis?					48. Transplants or artificial replacements?			
23.	Gallbladder trouble?					49. Are you on a diet?			
24.	Fainting spells?					50. Have you had anything to eat or drink in the last 6 hours?			
25.	Convulsions, epilepsy?					51. Who is driving you home today?			
26.	Stroke?								

C. MEDICATIONS	YES	NO
1. ARE YOU NOW TAKING ANY KIND OF MEDICINE, DRUG OR PILLS FOR ANY PURPOSE? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Anticoagulants?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Tranquilizers?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cortisone?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Other Medications? (Please List)..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....		

D. ALLERGIES	YES	NO
1. ARE YOU ALLERGIC TO OR HAD A REACTION TO LOCAL ANESTHETICS?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Penicillin?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Other antibiotics?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sodium pentothal, Valium, or other tranquilizers?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Aspirin?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Codeine or other narcotics?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Other medications?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Allergies other than drug allergies? (Please List)..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.....		

E. IS THERE ANY CONDITION CONCERNING YOUR HEALTH OR FAMILY'S ANESTHETIC HISTORY THAT THE DOCTOR SHOULD BE TOLD?	YES	NO
..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F. WOMEN:	YES	NO
1. Is there a risk that you may be pregnant?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Estimated delivery date?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you nursing?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you taking birth control pills?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.</p>		

I certify that I have read and understand the questions 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/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____ Date: _____
 (Parent or Guardian if Minor)

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 TMJ
 OE
