PATIENT HEALTH HISTORY

Describe the reason for this visit: _____

When were you last examined by a medical doctor and for what? _____

List all medications you are currently taking (including non-prescription, homeopathic or "natural" remedies): _____

_____

List any allergies to drugs/medications: _____

What operations/surgeries have you had since birth? _____

Please describe any other medical problems or condition which may affect your treatment in this office? _____

_____

Height: _____ Weight _____

	Yes	No
Do you wear contact lenses?	_____	_____
Do you drink alcohol? If yes, how much?	_____	_____
Do you smoke cigarettes? If yes, how much?	_____	_____
Do you use recreational/street drugs?	_____	_____
Have you ever had local anesthesia (novacaine)	_____	_____
Have you ever been put to sleep for an operation?	_____	_____
Have you or anyone in your family ever had a problem with anesthesia? If so, specify_____	_____	_____
Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, Reclast, Boniva, Aredia or Zometa) for osteoporosis, chemotherapy, multiple myeloma, or Cancer? Intravenous (IV) or pill form	_____	_____

PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR CURRENTLY HAVE

- ☐ High Blood Pressure
- ☐ Circulatory Problems (stroke)
- ☐ Shortness of Breath
- ☐ Asthma or Lung Disease
- ☐ Respiratory problems, emphysema
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Cancer
- ☐ Tumor or growth
- ☐ Radiation or Chemotherapy
- ☐ Liver Disease/Jaundice
- ☐ Hepatitis or Mononucleosis
- ☐ Positive Test for HIV or Aids Virus
- ☐ Viral Infection such as Herpes
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Blood transfusions
- ☐ Psychiatric/Mental Disorders
- ☐ Candidiasis (Fungal Infection)
- ☐ Seizure Disorder (epilepsy)
- ☐ TMJ/Jaw Problems
- ☐ Arthritis
- ☐ Thyroid or Glandular Disease
- ☐ Glaucoma
- ☐ *Heart Murmur
- ☐ *Artificial/Prosthetic Heart Valve
- ☐ *Heart Disease/Chest Pain
- ☐ *Vascular Grafts
- ☐ *Mitral Valve Prolapse
- ☐ *Bone or Joint Replacements
- ☐ **None of the above**

***If you answered yes to any of these questions, have you been told by your physician that you should have antibiotics prior to dental treatment?** ☐ **Yes** ☐ **No**

FOR WOMEN ONLY

Are you pregnant or trying to become pregnant?	☐ Yes	☐ No
Are you breastfeeding?	☐ Yes	☐ No
Are you taking the birth control pill?	☐ Yes	☐ No
Do you understand that antibiotics, which might be prescribed for you, may interfere with the function of the birth control pill?	☐ Yes	☐ No

Is there anything you would like to discuss in private with your oral surgeon? ☐ Yes ☐ No

I hereby authorize release of my dental/medical information to Dr. Malik and release of my dental/medical information from Dr. Malik to my dentist or medical doctor as necessary.

Signature of Patient or Legal Guardian	Date	Signature of Doctor	Date
_____	_____	_____	_____

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions or changes	Patient signature	Doctor's initials
_____	_____	_____	_____

GRANITE STATE ORAL SURGERY