Hassan Oral Surgery

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MEDICAL HISTORY

PATIENT'S NAME_____ DOB _____

1. Are you under a physician's care now? ___Yes ___No If yes, please explain: _____
2. Are you allergic to : □ **Penicillin** □ **Codiene** □ **local injected anesthetics** □ **Latex** □ **other** _____
3. What medications are you currently taking? _____
4. Have you ever had any **joint replacement** (such as knee or hip) or **heart valve replacements**? ___Yes ___ No
5. Are you taking Coumadin, Warfarin, or any other blood thinners? ___ Yes ___ No

Physician's name: _____ city, state _____ph # _____

HAVE YOU EVER BEEN TREATED FOR…

Mitral Valve Prolapse……Yes □ No □
Heart Disease……Yes □ No □
Rheumatic Fever……Yes □ No □
Abnormal Blood Pressure……Yes □ No □
Jaundice……Yes □ No □
HIV/AIDS……Yes □ No □
Tuberculosis/Lung Disease……Yes □ No □
Asthma/ Hay Fever……Yes □ No □
Hepatitis……Yes □ No □
Stroke……Yes □ No □
Glaucoma……Yes □ No □
Prolonged bleeding……Yes □ No □

(Woman) Are you pregnant? Yes □ No □ how long____
Epilepsy……Yes □ No □
Heart Murmur……Yes □ No □
Congenital Heart Lesions……Yes □ No □
Venereal Disease……Yes □ No □
Ulcers……Yes □ No □
Diabetes……Yes □ No □
Sinus Trouble……Yes □ No □
Arthritis……Yes □ No □
Cancer……Yes □ No □
Artificial joint or heart valve……Yes □ No □
Fainting spells……Yes □ No □

Have you ever had any serious illness not listed above? ___Yes ___No If yes, please explain:_____

_____

To the best of my knowledge, the questions on this form have been answered truthfully. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform this office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____DATE_____