TRI-STATE ORAL SURGERY

Medical History

Name: _____

Height: _____ Weight: _____

1. Dentist's Name: _____
2. Physician's Name: _____
3. Are you taking any medications? Yes No
   List: _____
4. Do you have any drug allergies? Yes No
   List: _____ _____
5. Do you have any medical problems? Yes No
   List: _____
6. Have you had previous surgeries? Yes No
   List: _____
7. Do you smoke Yes No
   How much per day_____
8. Do you have high blood pressure? Yes No
9. Do you have heart disease? Yes No
10. Do you have lung disease? Yes No
11. Do you have diabetes? Yes No
12. Are you taking blood thinners? Yes No
13. Have you had a joint replaced? Yes No
14. Have you been treated for cancer? Yes No
15. Are you or have you ever been treated for osteoporosis? Yes No
16. Do you have a history of alcohol or chemical dependency? Yes No
17. Have you or anybody in your family had a problems with anesthesia? Yes No
18. Are you pregnant or is there any chance you are pregnant? Yes No

It is important that you understand that antibiotics 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 is completed.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

_____ _____

Signature of Person Completing Health History **Date**

Returning Patients Only

There has been no change in the above Medical History.

_____ _____

Signature of Person Reviewing Health History **Date**