TRI-STATE ORAL SURGERY

Medical History

Name: _____ Height: _____ Weight: _____

1. Dentist's name: _____ Physician's name: _____

   Preferred pharmacy location: _____

2. Are you taking any medications? Yes No
   List: _____
3. Do you have any drug allergies? Yes No
   List: _____
4. Do you have any medical problems? Yes No
   List: _____
5. Have you had previous surgeries? Yes No
   List: _____
6. Do you use any tobacco products (cigarettes, electronic cigarettes, smokeless tobacco, etc.)? Yes No

   How much of these products do you use per day_____

7. Do you have high blood pressure? Yes No
8. Do you have heart disease? Yes No
9. Do you have lung disease? Yes No
10. Do you have diabetes? Yes No
11. Are you taking blood thinners? Yes No
12. Have you had a joint replaced? Yes No
13. Have you been treated for cancer? Yes No
14. Are you or have you ever been treated for osteoporosis? Yes No
15. Do you have sleep apnea? Yes No
16. Do you have a history of alcohol or chemical dependency? Yes No

    How often do you consume alcohol? (socially, rarely, never) _____
17. Have you or anybody in your family had a problem 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 Sign Below

_____ _____

Signature of Person Reviewing Health History **Date**