

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

DOCTOR'S NOTES

- Yes No A. Local Anesthesia (Novocaine, etc.)?
- Yes No B. Penicillin or other antibiotics?
- Yes No C. Sedatives, Barbiturates?
- Yes No D. Aspirin or Ibuprofen?
- Yes No E. Codeine or other pain killers?
- Yes No F. Latex or Rubber Products?
- Yes No G. Other allergies or reactions? Please, list

- Yes No 10. Do you smoke or chew Tobacco?
How much per day? _____
- Yes No .. 11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?
- Yes No .. 12. Are you currently or have you recently used recreational drugs (such as cocaine, marijuana, or methamphetamines)? This is critical information if we use IV medications for your treatment.
- Yes No .. 13. Have you had any serious problems associated with any previous dental treatment?
- Yes No .. 14. Have you or an immediate family member had any problem associated with intravenous anesthesia?
- Yes No .. 15. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?
- Yes No .. 16. Do you wish to talk to the doctor privately about anything?

17. FEMALES ONLY

- Yes No A. Are you Pregnant, or is there any chance you might be Pregnant?
- Yes No B. Are you nursing?

** If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) 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 or other medication is completed. Please consult with your physician for further guidance.

WHAT IS YOUR CHIEF COMPLAINT OR CONCERN TODAY?

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

_____ Date _____ Signature of Person Completing Health History _____ Doctor Initials _____

FOR COMPLETION BY THE ORAL SURGEON

Comments on patient interview concerning medical history _____

