MEDICAL HISTORY (ALL RESPONSES ARE KEPT CONFIDENTIAL)

Answer all questions by circling YES (Y) or No (N)

1. Have you ever had any adverse effects from dental treatment? ..... Y N
2. Do you wear a denture or removable appliance? Y N
3. Clicking or Popping of the Jaw Joint, Pain Near Ear, Difficulty Opening Mouth, Grind or Clench Teeth?..... Y N
4. Have you or a family member had problems with general anesthesia?……Y N
5. Do you snore or have you been diagnosed with sleep apnea?……Y N
6. Do you smoke or chew tobacco? ..... Y N
7. Do you use Marijuana or other "street drugs"? ... Y N
8. Do you use alcohol? ..... Y N
9. Are you pregnant or nursing?……Y N
   If yes, how many months _____
10. Do you wear contact lenses?……Y N
11. Are you wearing any oral piercings?……Y N

Are you taking any of the following medications: If yes, please indicate name of medication(s).

1. Thyroid Medications..... Y N
2. Antibiotics or Sulfa Drugs ..... Y N
3. Anticoagulants (Blood Thinners)..... Y N
4. High blood Pressure Medicine..... Y N
5. Steroids (Cortisone, etc.) ..... Y N
6. Tranquilizers (Valium, etc.)..... Y N
7. Insulin or Anti-Diabetic drug..... Y N
8. Digitalis, Inderal, Nitroglycerin,Calcium Channel Blockers, Procardia, or other Heart Medicine?... Y N
9. Aspirin or Ibuprofen ..... Y N
   If so, how much daily _____
10. Antihistamines or Decongestants..... Y N

Are you allergic or had a bad reaction to: If answering yes, please circle condition(s).

1. Local Anesthetic (Novocaine, etc.)…… Y N
2. Penicillin, Amoxicillin, Cephalosporins or other Antibiotics..... Y N
3. Barbiturates, Sedatives, etc. ..... Y N
4. Aspirin or Ibuprofen ..... Y N
5. Codeine or other Pain Killers..... Y N
6. Latex or Rubber Products ..... Y N
7. Eggs ..... Y N
8. Soybeans…….. Y N
9. Sulfa ……..Y N
9. Other Allergies or Reactions_____Y N

Do you have or have you ever had: If answering yes, please circle condition(s) that pertains to you.

1. Scarlet or Rheumatic Fever ..... Y N
2. Congenital heart disease …… Y N
3. Cardiovascular Disease/Heart Condition……Y N
   - Angina…….. Y N
   - Heart murmur……. Y N
   - Heart attack: if yes, when_____ Y N
   - Heart surgery: if yes, when_____ Y N
   - High blood pressure…… Y N
   - Low blood pressure…… Y N
   - Pacemaker…….. Y N
   - Stroke…….. Y N
4. Lung Disease
   - Asthma……Y N
   - Emphysema……Y N
   - Bronchitis……Y N
   - Tuberculosis……Y N
   - Shortness of breath……. Y N
   - Pneumonia……...Y N
5. Bleeding Disorder
   - Anemia……Y N
   - Bleed or bruise easily……. Y N
6. Nervous Disorder
   - Epilepsy/Seizures…….. Y N
   - Fainting …… Y N
   - Psychiatric treatment…… Y N
7. Liver Disease (Jaundice, Hepatitis) ..... Y N
8. Kidney Disease ..... Y N
9. Diabetes ..... Y N
10. Thyroid Disease ..... Y N
11. Arthritis..... Y N
12. Stomach Ulcers or Colitis ..... Y N
13. Glaucoma..... Y N
14. Bone disease
    - Medications _____
15. Treatment for Cancer
    - Surgery……. Y N
    - Radiation…….. Y N
    - Chemotherapy…….. Y N
    - Oral cancer drugs……. Y N
16. Immune System …… Y N
    - HIV/AIDS…….. Y N
17. Have you had an organ or tissue transplant…Y N
18. Frequent or Recurring Mouth Sores ..... .Y N
19. Implants placed anywhere in your body (Heart Valve, Hip, Knee)..... Y N
20. Sinus or Nasal Problems? ..... Y N

- Do you have any other disease or condition not listed above that the doctor should know about?……Y N
  If yes, please list _____

- Do you wish to talk to the doctor privately about anything? ..... Y N

For Women Only:

- Antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Please advise the doctor if there is any chance of your being pregnant.

MEDICAL DOCTOR _____

HEIGHT _____ WEIGHT _____

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

_____ _____ _____

Patient Name | Signature of person completing Health History | Doctor's Initials

DR. EDWARD DELGADO

Diplomates of the American Board of Oral and Maxillofacial Surgery

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PLEASE LIST ALL MEDICATIONS BELOW THAT YOU ARE TAKING

MEDICATION	STRENGTH	FREQUENCY

PATIENT SIGNATURE _____ DATE _____