

SEDATION HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your responses.

Hear Murmur (mitral valve prolapse)	No	Yes
Anemia	No	Yes
Epilepsy	No	Yes
Diabetes	No	Yes
Hepatitis, any form	No	Yes
Rheumatic Fever	No	Yes
Asthma	No	Yes
HIV positive or AIDS related complex	No	Yes
Emphysema or respiratory illness	No	Yes
Abnormal Heart condition (disease or attack)	No	Yes
Kidney disease	No	Yes
Venereal disease	No	Yes
Psychosis	No	Yes
Sore/enlarged lymph nodes	No	Yes
Previous Biopsies	No	Yes
Slow-healing mouth sores	No	Yes
Other infections	No	Yes
Recurrent illnesses	No	Yes
Joint replacement	No	Yes
Glaucoma	No	Yes
Abnormal bleeding from a cut	No	Yes
Liver disease (including Jaundice)	No	Yes
Unintentional weight loss/gain	No	Yes
Latex sensitivity	No	Yes

Are you required to pre-medicate with antibiotics before dental treatment? No Yes

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal blood pressure? (Please circle) No Yes
If yes, what is it usually S /D

Are you allergic or have you had a reaction to:
Local anesthetics No Yes
Penicillin or other antibiotics No Yes
Aspirin No Yes
Codeine, valium or other sedatives No Yes
Other _____

Are you a smoker? No Yes
If yes, how much do you smoke per day? _____

Do you consume grapefruit or grapefruit juice regularly? No Yes

Please list any medications you are currently taking:
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Are you taking Tagamet (Cimetadine) or any other antacids? No Yes
If yes, How often? _____

Are you taking any herbal supplements/medicines? No Yes
If so, which ones? _____

Diet: Restricted Diet _____
How many meals per Day? _____
Food allergies? _____
Sugar in your diet: ___ none ___ slight ___ moderate ___ high

DOCTOR'S USE ONLY

Comment on patient interview concerning medical history: _____

Patient (print)

Patient Signature

Date