Sedation Health History

Name________________________________ Date_____________

Date of last heath care exam: __________________

What was this exam for? ____

Have you been hospitalized or had surgery? *(Please circle) Yes or No*

If yes, reason: ____

Are you currently receiving care? *(Please circle) Yes or No*

If yes, nature of care: ____

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

- ____________________________________
- ____________________________________
- ____________________________________
- ____________________________________

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 response. Our team may ask for additional questions concerning your health.

Blood Disorders	Yes	No	Hepatitis, any form	Yes	No
Arthritis, Rheumatism, or other inflammatory disease	Yes	No	Joint Replacement? When replaced?	Yes	No
Asthma, COPD, or other lung diseases	Yes	No	Kidney Disease	Yes	No
Abnormal bleeding from a cut	Yes	No	Liver Disease (including Jaundice)	Yes	No
Cancer or Tumor	Yes	No	Sore/enlarged lymph nodes	Yes	No
Diabetes	Yes	No	Psychiatric therapy	Yes	No
Emphysema or other respiratory/lung illnesses	Yes	No	Previous biopsies	Yes	No
Epilepsy	Yes	No	Radiation or Chemotherapy	Yes	No
Fainting or dizzy spells	Yes	No	Renal Dialysis	Yes	No
Glaucoma	Yes	No	Slow-Healing mouth sores	Yes	No
Previous Bacterial Endocarditis	Yes	No	Unintentional weight loss/gain	Yes	No
Heart Valve (artificial) or Heart Transplant	Yes	No	H.I.V infection/AIDS	Yes	No
Congenital Heart Disease	Yes	No	Venereal disease	Yes	No
Heart Disease, Heart Attack, Heart Surgery, Angina	Yes	No	Other conditions	Yes	No

Heart Stent? When placed?	Yes	No	Recurrent illnesses	Yes	No

Are you taking any of these medications?

Pre-medication before dental treatment?	Yes	No	Biaxin (Clarithromycin)	Yes	No
Antacids	Yes	No	Cardizem (Diltiazem) or Calan, Isoptin (Verapamil)	Yes	No
St. John's Wort or Kava-Kava	Yes	No	Barbiturates (any)	Yes	No
Dilantin or Tegretol	Yes	No	Diflucan (Fluconazole) or Sporonox (Itraconazole)	Yes	No
Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva, Reclast, or Prolia? If so, when did you start? When did you end?				Yes	No
Do you consume grapefruit juice, grapefruits, or grapefruit extract?				Yes	No

Please list any medications you are currently taking and dosages:

- ____
- ____
- ____
- ____
- ____
- ____

Please list any dietary or herbal supplements you are taking, and for what purpose:

- ____
- ____
- ____
- ____
- ____
- ____

Do you use recreational drugs *(Please circle)* *Yes or No*

If so, which ones? ______________________________________

Sleep:

- Do you suspect or have you been told that you snore? *Y or N*
- Do you suspect or have you been diagnosed with sleep apnea? *Y or N*
- Are you being treated for sleep apnea with a CPAP, BiPAP, or another device? *Y or N*

Women: Are you pregnant?

If no, are you planning a pregnancy in the near future? *Yes or No*

- Are you a nursing mother? *Yes or No*
- Are you taking birth control pills? *Yes or No*

Abnormal Blood Pressure? *(Please circle) Yes or No*

- Have you ever received a diagnosis of "high blood pressure" or "low blood pressure"?

  What is your normal blood pressure? S D/ Today: ________/_________

Are you allergic or have you had a reaction to:

- Local anesthetics or epinephrine……………......
- Penicillin or other antibiotics……………….
- Aspirin, Ibuprofen or Tylenol……………………
- Codeine, Valium, Hydrocodone, Oxycodone, or other sedatives…..........
- Latex or Metals……......
- Other (please specify) ________________________________

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: Smoke or Chew How much per day?_____________ For how long?_______________	Yes	No
Do you want to quit using tobacco?	Yes	No
Do you consume alcohol? If yes, how many beverages per week? __________	Yes	No
Do you use any mood-altering drugs other than those previously listed?	Yes	No

Weight and Diet Considerations

Weight	**Height**	**Meals per Day**	**Dietary Restrictions**	**Food Allergies**
Sugar in your diet? (Circle one) None Slight Moderate High				

Comments on patient interview concerning medical history:

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____

____

Significant findings from questionnaire or oral interview:

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____

____

Dental management considerations:

____

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I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health and medication.

Patient (Print Name) ____

Patient Signature ____ Date ______________________

Doctor (Print Name) ____

Doctor Signature ____ Date ______________________