GRANITE STATE ORAL SURGERY

PATIENT HEALTH HISTORY

Describe the reason for this visit: _____

When were you last examined by a medical doctor and for what? _____

List all medications you are currently taking (including non-prescription, homeopathic or "natural" remedies):_____

_____

List any allergies to drugs/medications: _____

What operations/surgeries have you had since birth? _____

Please describe any other medical problems or condition which may affect your treatment in this office?

Height: _____ Weight _____

	Yes	No
Do you wear contact lenses?	____	____
Do you drink alcohol? If yes, how much?	____	____
Do you smoke cigarettes? If yes, how much?	____	____.
Do you use recreational/street drugs?	____	____
Have you ever had local anesthesia (novacaine)	____	____
Have you ever been put to sleep for an operation?	____	____
Have you or anyone in your family ever had a problem with anesthesia? If so, specify _____	____	____
Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, Reclast, Boniva, Aredia or Zometa) for osteoporosis, chemotherapy, multiple myeloma, or Cancer? Intravenous (IV) or pill form	____	____

PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR CURRENTLY HAVE

- ☐ High Blood Pressure
- ☐ Circulatory Problems (stroke)
- ☐ Shortness of Breath
- ☐ Asthma or Lung Disease
- ☐ Respiratory problems, emphysema
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Cancer
- ☐ Tumor or growth
- ☐ Radiation or Chemotherapy
- ☐ Liver Disease/Jaundice
- ☐ Hepatitis or Mononucleosis
- ☐ Positive Test for HIV or Aids Virus
- ☐ Viral Infection such as Herpes
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Blood transfusions
- ☐ Psychiatric/Mental Disorders
- ☐ Candidiasis (Fungal Infection)
- ☐ Seizure Disorder (epilepsy)
- ☐ TMJ/Jaw Problems
- ☐ Arthritis
- ☐ Thyroid or Glandular Disease
- ☐ Glaucoma
- ☐ *Heart Murmur
- ☐ *Artificial/Prosthetic Heart Valve
- ☐ *Heart Disease/Chest Pain
- ☐ *Vascular Grafts
- ☐ *Mitral Valve Prolapse
- ☐ *Bone or Joint Replacements
- ☐ **None of the above**

***If you answered yes to any of these questions, have you been told by your physician that you should have antibiotics prior to dental treatment? Yes No**

FOR WOMEN ONLY

Are you pregnant?	Yes	No
Are you trying to become pregnant?	Yes	No
Are you breastfeeding?	Yes	No
Are you taking the birth control pill?	Yes	No
Do you understand that antibiotics, which might be prescribed for you, may interfere with the function of the birth control pill?	Yes	No

Is there anything you would like to discuss in private with your oral surgeon? ..... Yes No

I hereby authorize release of my dental/medical information to Dr. Malik and release of my dental/medical information from Dr. Malik to my dentist or medical doctor as necessary.

_____ _____ _____ _____

Signature of Patient or Legal Guardian | Date | Signature of Doctor | Date

---

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

_____ _____ _____ _____

Date | Exceptions or changes | Patient signature | Doctor's initials