SOUTHEASTERN PENNSYLVANIA ORAL SURGERY

EPISCOPAL HOSPITAL
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To our patients:
Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit _____

_____

A.

		YES	NO
1.	Are you in good health? ..... Height _____ Weight _____	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ..... Date of last visit: _____ If so, for what are you being treated? _____	❑	❑
4.	Have you had any illness, operation or been hospitalized in the past five years? _____	❑	❑
5.	Do you have unhealed injuries or inflamed areas in or around your mouth, growth or sore spots in your mouth? ..... If so, describe where _____	❑	❑

B.

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE	Yes	No	NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE	Yes	No	NOTES
1	Rheumatic fever?				21	Convulsions, epilepsy?			
2	Damaged heart valves/ mitral valve prolapse?				22	Stroke?			
3	Heart murmur?				23	Thyroid trouble?			
4	High/low blood pressure?				24	Diabetes / low blood sugar?			
5	Chest pain, angina?				25	Kidney trouble?			
6	Heart attack(s)?				26	Are you on dialysis?			
7	Irregular heart beat?				27	Urinary problems?			
8	Cardiac pacemaker?				28	Contagious diseases / Sexually transmitted diseases?			
9	Heart surgery?				29	AIDS or HIV infection?			
10	Bronchitis, chronic cough?				30	Problems of the immune system?			
11	Hayfever / Sinus problems?				31	Mental health problems?			
12	Asthma / Chronic lung disease?				32	Are you wearing a removable dental appliance?			
13	Do you smoke?				33	Habit-forming drugs?			
14	Blood transfusion?				34	Alcohol beverages?			
15	Blood disorder such as anemia?				35	Contact lenses?			
16	Bruise easily?				36	X-Ray treatment / chemotherapy?			
17	Bleeding tendency (abnormal bleed?)				37	Pain & clicking of jaws when eating?			
18	Jaundice, hepatitis or liver disease?				38	Malignant Hyperthermia?			
19	Blood clots?								
20	Fainting spells?								

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Name _____ D.O.B. _____ Date _____

C.	MEDICATIONS	YES	NO
1.	**ARE YOU NOW TAKING ANY KIND OF MEDICINE, DRUG OR PILLS FOR ANY PURPOSE?**	❑	❑
2.	Anticoagulants?	❑	❑
3.	Tranquilizers?	❑	❑
4.	Cortisone?	❑	❑
5.	Other medications? (Please list)	❑	❑

D.	ALLERGIES	YES	NO
1.	**ARE YOU ALLERGIC TO OR HAD A REACTION TO LOCAL ANESTHETICS?**	❑	❑
2.	Penicillin?	❑	❑
3.	Other antibiotics?	❑	❑
4.	Sodium pentothal, Valium, or other tranquilizers?	❑	❑
5.	Aspirin?	❑	❑
6.	Codeine or other narcotics?	❑	❑
7.	Other medications?	❑	❑
8.	Allergies other than drug allergies? (Please list)	❑	❑

E.	**IS THERE ANY CONDITION CONCERNING YOUR HEALTH OR FAMILY'S ANESTHETIC HISTORY THAT THE DOCTOR SHOULD BE TOLD?**	❑	❑

F.	**WOMEN:**		
1.	Is there a possibility that you may be pregnant?	❑	❑
2.	Estimated delivery date?	❑	❑
3.	Are you nursing?	❑	❑
4.	Are you taking birth control pills?	❑	❑

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecololgist for assistance regarding additional methods of birth control.

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____ Date: _____
(Parent or Guardian if minor)

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Name _____ D.O.B. _____ Date _____