Jeffrey P. Fisher, DDS

"Anesthesia for Dentistry"

Medical/Health History

(For patients12 years of age and older)

Patient's Name: _____ Date of Birth: _____ Gender: ____ Age: _____ Weight: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Tel: (____)_____ Cell/Work: (____)_____ Comments:_____

List *all medications* which you are currently taking (including vitamins, herbs, and laxatives): _____

_____

Do you have *allergies* to any medications or foods? Yes No If yes, which ones? _____

1. Are you in good health? _____ Yes No
2. Are you currently under the care of a physician? _____ Yes No
3. Have you had any serious illness, operation, or been hospitalized in the last 5 years?_____ Yes No
4. Do you have or have you had in the past any of the following heart diseases or complications?
   - Congenital heart defects or murmurs? _____ Yes No
   - Damaged heart valves, malfunctioning heart valves, or artificial heart valves? _____ Yes No
   - Arrhythmias or irregular heart beats? _____ Yes No
   - Ventricular septal defect or atrial septal defect? _____ Yes No
5. Do you have or have you had in the past any of the following cardiovascular complications?
   - Chest pain upon exertion? _____ Yes No
   - Shortness of breath after mild exercise or when lying down? _____ Yes No
   - Swelling in the ankles? _____ Yes No
   - High blood pressure? _____ Yes No
   - Stoke or transient ischemic attack?_____ Yes No
   - Heart transplant?_____ Yes No
6. Do you have or have you had in the past any of the following lung diseases or complications?
   - Asthma or reactive airway disease? _____ Yes No
   - Bronchitis, pneumonia, emphysema, tuberculosis, chronic cough?_____ Yes No
   - Chronic sinus problems or seasonal allergies?_____ Yes No
   - Current cold or flu symptoms?_____ Yes No
7. Do you have or have you had in the past any of the following diseases or complications?
   - Liver disease (hepatitis or jaundice)?_____ Yes No
   - Kidney disease? _____ Yes No
   - Thyroid disease? _____ Yes No
   - Diabetes? _____ Yes No
   - Stomach problems (ulcers, excess stomach acid with heart burn, persistent diarrhea and or weight loss)? ____ Yes No
   - Arthritis, swollen and painful joints and lymph nodes?_____ Yes No
   - Seizures (epilepsy), fainting spells, or other neurological problems? _____ Yes No
   - Mental retardation, autism, or any other problems with mental health? _____ Yes No
   - Cancer? _____ Yes No
   - Sexually transmitted diseases, HIV, AIDS? _____ Yes No
8. Do you bruise easily or have you ever been diagnosed with bleeding disorder? _____ Yes No
9. Do you have any blood disorders such as anemia or sickle cell anemia? _____ Yes No
10. Have any of your blood relatives ever had a bad reaction to anesthesia? _____ Yes No
11. Do you have any disease, condition, or complication not mentioned above? _____ Yes No
    If yes, please explain:_____

I understand that withholding any information about my health history could seriously jeopardize my safety. Therefore, I have reviewed the above medical/health history carefully and have answered all questions truthfully and to the best of my knowledge.

Patient's Signature: _____ **Printed Name:** _____ **Date:** _____

(*Or signature of parent/guardian for patient unable to complete this form*) (*Patient or parent/guardian*)