

Please list all your operations, surgeries, and hospitalization: _____

- * Are you now under a physician's care, or have you been during the past five years, including hospitalization (s) and surgery? YES NO
[] []
- * Have you taken Cortisone or other steroids in the past 24 month's _____ [] []
- * Have you had opthalmic (eye) surgery in the past 8 weeks? [] []
- * Have you or your family had a reaction to dental or general anesthetic? _____ [] []
- * Have you had any adverse effects from dental treatment? _____ [] []
- * When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? [] []
- * Are you in good health? _____ [] []
- * Has there been any change in your general health in the past year? _____ [] []
- * Date of last physical exam _____
- * Do you wish to talk with the doctor privately about anything? [] []
- * WOMEN: Could you be pregnant? [] []
Do you anticipate becoming pregnant in the upcoming year [] []
Are you currently breast feeding? [] []
Are you taking birth control pills? [] []
Do you wish to have a pregnancy test? [] []

WOMEN NOTE:

- A. If you are using birth control pills it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Please consult with your physician for assistance regarding additional methods of birth control.
- B. If you are pregnant, POSSIBLY pregnant or trying to become pregnant, surgery, anesthetics or any other medications may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant!

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory tests, or if my medicines change, I will inform the doctor at the next appointment without fail. I have had a chance to ask questions. I understand x-rays and local anesthetics may be required for treatment. I also state I read and write in English, or this information has been translated to me in my primary language.

Date Signature of Patient, Parent or Guardian if under 18

Date Witness

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FOR OFFICE USE ONLY FOR OFFICE USE ONLY FOR OFFICE USE ONLY

Height____; Weight____; BP____; Pulse____; Resp____; Temp____; Age____

HEALTH COMMENTS AND SUMMARY: ASA I II III IV

ROS: _____

I have reviewed and discussed this patient's past Medical History

Date Doctor's Signature
Height____; Weight____; BP____; Pulse____; Resp____; Temp____; Age____

HEALTH COMMENTS AND SUMMARY: ASA I II III IV

ROS: _____

I have reviewed and discussed this patient's past Medical History

Date Doctor's Signature

MEDICAL HISTORY REVIEW/UPDATE

Date Patient's Signature, Parent or Guardian Doctor's Signature