MEDICAL HISTORY (ALL RESPONSES ARE KEPT CONFIDENTIAL)

____________	____________	____________	____________	______	______
Patient's Name	**General Dentist**	**Referring Doctor**	**Medical Doctor**	**Height**	**Weight**

Answer all questions by circling YES (Y) or No (N)

1. Have you ever had any adverse effects from dental treatment? .... Y N
2. Do you wear a denture or removable appliance? Y N
3. Clicking or Popping of the Jaw Joint, Pain Near Ear, Difficulty Opening Mouth, Grind or Clench Teeth?.......... Y N
4. Have you or a family member had problems with general anesthesia?.......... Y N
5. Do you snore or have you been diagnosed with sleep apnea?.......... Y N
6. Do you smoke or chew tobacco? .... Y N
7. Do you use Marijuana or other "street drugs"?.... Y N
8. Do you use alcohol? .... Y N
9. Are you pregnant or nursing?.......... Y N
   If yes, how many months ______________________
10. Do you wear contact lenses?.......... Y N
11. Are you wearing any oral piercings?.......... Y N

Are you taking any of the following medications:
If yes, please indicate name of medication(s).

1. Thyroid Medications.......... Y N
2. Antibiotics or Sulfa Drugs .... Y N
3. Anticoagulants (Blood Thinners).......... Y N
4. High blood Pressure Medicine.......... Y N
5. Steroids (Cortisone, etc.) .... Y N
6. Tranquilizers (Valium, etc.).......... Y N
7. Insulin or Anti-Diabetic drug.......... Y N
8. Digitalis, Inderal, Nitroglycerin,Calcium Channel Blockers, Procardia, or other Heart Medicine?... Y N
9. Aspirin or Ibuprofen .... Y N
   If so, how much daily ____________________
10. Antihistamines or Decongestants.......... Y N
11. **PLEASE LIST ALL MEDICATIONS YOU ARE TAKING ON THE BACK SIDE OF THIS FORM.**

Are you allergic or had a bad reaction to: If answering yes, please circle condition(s).

1. Local Anesthetic (Novocaine, etc.).......... Y N
2. Penicillin, Amoxicillin, Cephalosporins or other Antibiotics.......... Y N
3. Barbiturates, Sedatives, etc. .... Y N
4. Aspirin or Ibuprofen .... Y N
5. Codeine or other Pain Killers .... Y N
6. Latex or Rubber Products .... Y N
7. Eggs .... Y N
8. Soybeans.......... Y N
9. Sulfa .... Y N
9. Other Allergies or Reactions________________ Y N

Do you have or have you ever had: If answering yes, please circle condition(s) that pertains to you.

1. Scarlet or Rheumatic Fever .... Y N
2. Congenital heart disease .... Y N
3. Cardiovascular Disease/Heart Condition...... Y N
   - Angina.......... Y N
   - Heart murmur.......... Y N
   - Heart attack: if yes, when___________ Y N
   - Heart surgery: if yes, when__________ Y N
   - High blood pressure.......... Y N
   - Low blood pressure.......... Y N
   - Pacemaker.......... Y N
   - Stroke.......... Y N
4. Lung Disease
   - Asthma.......... Y N
   - Emphysema.......... Y N
   - Bronchitis.......... Y N
   - Tuberculosis.......... Y N
   - Shortness of breath.......... Y N
   - Pneumonia.......... Y N
5. Bleeding Disorder
   - Anemia.......... Y N
   - Bleed or bruise easily.......... Y N
6. Nervous Disorder
   - Epilepsy/Seizures.......... Y N
   - Fainting .... Y N
   - Psychiatric treatment.......... Y N
7. Liver Disease (Jaundice, Hepatitis) .... Y N
8. Kidney Disease .... Y N
9. Diabetes .... Y N
10. Thyroid Disease .... Y N
11. Arthritis .... Y N
12. Stomach Ulcers or Colitis.......... Y N
13. Glaucoma.......... Y N
14. Bone disease
    - Medications ________________________
15. Treatment for Cancer
    - Surgery.......... Y N
    - Radiation.......... Y N
    - Chemotherapy.......... Y N
    - Oral cancer drugs.......... Y N
16. Immune System .... Y N
    - HIV/AIDS.......... Y N
17. Have you had an organ or tissue transplant... Y N
18. Frequent or Recurring Mouth Sores .... .Y N
19. Implants placed anywhere in your body (Heart Valve, Hip, Knee).......... Y N
20. Sinus or Nasal Problems?.......... Y N

- Do you have any other disease or condition not listed above that the doctor should know about?.......... Y N
  If yes, please list ______________________________

- Do you wish to talk to the doctor privately about anything? .... Y N

For Women Only:

- Antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Please advise the doctor if there is any chance of your being pregnant.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

______________	______________________________	____________________
Date	Signature of person completing Health History	Doctor's Initials

DRS. DELGADO & KUZMIK, P.C.

Diplomates of the American Board of Oral and Maxillofacial Surgery

Edward B. Delgado, D.D.S.

Michael D. Kuzmik, D.D.S.

MEDICATION	STRENGTH	FREQUENCY

PATIENT SIGNATURE

DATE