STEPHEN E. NEEDLE, D.D.S. ORAL AND MAXILLOFACIAL SURGERY

HEALTH HISTORY

Patient Name_____ Date_____
First M.I. Last

Dental

Reason for visit today_____

Are you wearing any removable dental appliances?_____

Medical

	Y	N		Y	N		Y	N
Cardiovascular disease			Stroke			Respiratory problems		
Damaged heart valves			Nervousness, anxious			Emphysema		
Artificial heart valve			Fainting or dizzy spells			Bronchitis		
Rheumatic fever			Shortness of breath			Blood-producing cough		
Heart attack			Chronic fatigue			Asthma		
Pacemaker			Night sweats			Hay fever		
Irregular heartbeat			Psychiatric treatment			Persistent swollen glands		
Heart surgery			Hypoglycemia, low blood sugar			Arthritis or painful joints		
Angina			Diabetes			Swollen ankles		
Chest Pain			Weight loss or diarrhea			Joint replacement		
Congenital heart defect			Thyroid disease			Artificial bone		
Coronary insufficiency			Hepatitis, jaundice, liver disease			Abnormal bone values		
High Blood Pressure			HIV or AIDS			Stomach ulcer or hyperacidity		
Low Blood Pressure			Problems with immune system			Kidney disease		
Arteriosclerosis			Sexually transmitted disease			Dialysis		
Blood vessel grafts, stents			Cancer or tumor			Abnormal bleeding		
Excessive bleeding, bruising			Abnormal growth			Blood transfusion		
Delay in healing			Epilepsy, seizure, convulsion			Blood disorder		
			Glaucoma			Anemia		
OTHER **			Eye disease					

Medications, Drugs, Therapies

Do you pre-medicate prior to dental treatment? _____ If yes, what time did you pre-medicate today?_____

Please list all medications that you are taking._____

Are you receiving any chemotherapy or radiation therapy?_____

General Health

Height_____ Weight_____ Are you in good health?_____

Are you being treated by a physician? (please list name and phone#)_____

When was your last visit with physician?_____

For what are you being treated?_____

Have you ever been hospitalized or had surgery? (please describe)_____

Are there any conditions that the doctor should be aware of?_____

Have you ever had a serious reaction to any anesthesia, surgery or dental treatment?_____

If yes, please describe._____

Allergies or adverse reaction

	Y	N		Y	N		Y	N
Latex or rubber			Vicodin			Sulfa		
Penicillin or Amoxicillin			Novacaine			Sulfites		
Antibiotics			Codeine or narcotics			Eggs		
Tetracycline			Valium, tranquilizers			Soy		
Erythromycin			Sedatives, sleeping pills			Ibuprofen		
Aspirin			Iodine			Acetaminophen		

Other allergies not listed_____

Women

	Y	N		Y	N
Are you now pregnant?			Are you nursing?		
Are you using birth control pills?			Are you trying to get pregnant?		

Warning: Birth control pills are less effective while taking antibiotics. Please consult your physician for further guidance.

Special Needs and Disabilities

	Y	N		**Y**	**N**
Autism, Asperger's Syndrome, PDD-NOS			Down's Syndrome		
Fragile X or chromosome disorder			Bipolar Disorder		
Sensory Integration Disorder			ADHD, ADD		
Are you overly sensitive to light?			Do you like fidgets or sensory balls?		
Are you overly sensitive to music?			Do you like weighted blankets?		
Do you have oral sensory defensiveness, dislike certain textures in your mouth?			Do you have a fear of surgical masks on the doctor or surgical assistants?		
Do you dislike having your teeth brushed?			Do you have a fear of an oxygen mask being placed on you?		

Please describe any special accommodation that would be helpful during your visit?_____

_____

Please list your favorite things_____

_____

Recreational drugs and spirits

Your responses are strictly confidential, but they are necessary to determine the proper anesthesia and medications to be effective for your treatment.

	Y	**N**		**Y**	**N**		**Y**	**N**
Do you use marijuana?			Do you smoke cigarettes?			Do you use narcotics?		
Do you use cocaine?			Do you smoke cigars or a pipe?			Do you drink alcohol?		
Do you use crystal meth?			Do you chew tobacco?					
Do you have a history of drug abuse?			Do you have a history of alcohol abuse?					

Have you used any recreational drugs within the last month and if so, which?_____

I certify that I have read and understand the above. I acknowledge that my questions about any inquiries of the above questions have been answered to my satisfaction. I have answered the above questions to the best of my ability, and I will not hold the doctor or his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient signature Date

_____ _____

Doctor's signature Date