COMMENTS:

White Birch Oral Surgery
ADULT MEDICAL HISTORY

PATIENT'S NAME____DOB________

CIRCLE THE APPROPRIATE ANSWER

Physician's Name____

Address ____

1.	Are you under a physicians care …………………………………………......	YES	NO
	Since when?__________________________Why?_________________		
2.	When was your last complete physical exam?________________________		
3.	Are you taking any medications ?..	YES	NO
4.	Do you routinely take health related substances?..	YES	NO
5.	Are you allergic to any medications or substances?..	YES	NO
6.	Do you have any other allergies?..	YES	NO
7.	Do you have any problems with penicillin,antibiotics or any other medications?	YES	NO
8.	Are you sensitive to metals or latex?..	YES	NO
9.	Are you pregnant or suspect you may be?..	YES	NO
10.	Do you use any birth control medications?...	YES	NO
11.	Have you ever been treated for or been told you might have a heart disease?	YES	NO
12.	Do you have a pacemaker or an artificial heart valve implant?......................	YES	NO
13.	Have you ever had rheumatic fever?...	YES	NO
14.	Are you aware of any heart murmur?..	YES	NO
15.	Do you have high or low blood pressure?...	YES	NO
16.	Have you ever had a serious illness or major surgery?..................................	YES	NO
	If so please explain____		
17.	Have you ever had radiation treatment, chemo treatment for a tumor, growth, or other condition?..	YES	NO
18.	Do you have inflammatory diseases, such as arthritis or rheumatism?............	YES	NO
19.	Do you have any artificial joints/prosthesis?..	YES	NO
20.	Do you have any blood disorders, such as anemia, leukemia, etc?..................	YES	NO
21.	Have you ever bled excessively after being cut or injured?..............................	YES	NO
22.	Do you have stomach problems?..	YES	NO
23.	Do you have kidney problems?...	YES	NO
24.	Do you have liver problems?...	YES	NO
25.	Are you diabetic?...	YES	NO
26.	Do you have asthma?..	YES	NO
27.	Do you have epilepsy or seizure disorder?..	YES	NO
28.	Do you or have you had venereal disease?...	YES	NO
29.	Have you tested HIV positive?..	YES	NO
30.	Do you have AIDS?..	YES	NO
31.	Have you had or do you test positive for hepatitis?...	YES	NO
32.	Do you or have you had T.B.?...	YES	NO
33.	Do you smoke, chew, use snuff or other forms of tobacco?.............................	YES	NO
34.	Do you consume alcoholic beverages?...	YES	NO
35.	Do you habitually use controlled substances?..	YES	NO

COMMENTS:

36. Have you had psychiatric treatment?... YES NO
37. Do you have any disease, condition or problem not listed? ………………… YES NO
38. If so please explain?____
39. Is there anything else we should know about your health that we have not covered in this form?_______________________________________ YES NO
40. Would you like to speak to the Doctor privately about any problem?........... YES NO
41. **ARE YOU USING ANY OF THE FOLLOWING**
    - A. Antibiotics……………………………………………………………. YES NO
    - B. Anticoagulants (Blood Thinners?)………………………………….... YES NO
    - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?............................. YES NO
    - D. High Blood Pressure medications?.. YES NO
    - E. Steroids (Cortisone, Prednisone, etc.)?.. YES NO
    - F. Tranquilizers?.. YES NO
    - G. Insulin or Oral Anti-Diabetic drugs?.. YES NO
    - H. Digitalis, Inderal, Nitroglycerin or other heart drugs?............................ YES NO
    - I. Are you taking or ***have your ever taken*** Bisphosphonates for osteoporosis, Multiple myeloma or other cancers. (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)?.. YES NO
    - J. Have you ever been advised **not** to take a medication?............................. YES NO
    - K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals.____
      ____
      ____
      ____
      ____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE____DATE_____________

DOCTOR'S SIGNATURE____DATE_____________