Dr. Dale R. Duncan

North Atlanta Oral and Maxillofacial Surgery

HEALTH HISTORY

PATIENT'S NAME_____ **DATE** _____/_____/_____

1. **Family Physician** Name _____Phone_____
   Address _____
2. **Pharmacy** Name _____Phone_____
   Address _____
3. **Specialist** Name _____Phone_____
   Address _____
4. **Family Dentist** Name _____Phone_____
   Address _____

5. Have you taken any medicine or drugs during the past two years? CIRCLE: yes / no

6. Are you now taking any medications, drugs, or pills? **This includes any bone building drugs (Bisphosphonates) such as Actonel, Boniva, Fosamax, Zometa, etc.** If so, please list medicine and dosage –**please include Herbal Meds/Supplements**:_____
_____

7. Are you allergic or have you reacted adversely to any of the following medications? CIRCLE:

Aspirin	Nitrous Oxide	Local Anesthetic
Valium	Scopolamine	(Novocaine or Xylocaine)
Darvon	Erythromycin	Sleeping Pills
Codeine	Tetracycline	(Nembutal or Seconal)
Demerol	Penicillin	Ibuprofen
Percodan	Other Antibiotics	Latex

Are you aware of being allergic to any other medication or substance? CIRCLE: yes / no
If so, please list: _____

8. **Height:** _____ **Weight:** _____ Regular Exercise/Sport: _____
   Alcohol: _____ Tobacco: _____ Snoring/Sleep Apnea: _____
   Date of last physical: _____/_____/_____

9. **Circle** any of the following that you, the patient, have had or have at the present.

NOTE: It is imperative that all conditions, diagnoses, diseases are disclosed!

		Other Conditions Diagnosed/Date
Heart Failure	Emphysema	1._____
Heart Disease or Attack	Cough	_____
Angina Pectoris	Tuberculosis	Additional Info: _____
High Blood Pressure	Asthma or Shortness of Breath	_____
Heart Murmur	Hay Fever	_____
Rheumatic Fever	Sinus Trouble	2._____
Congenital Heart Lesions	Allergies or Hives	_____
Scarlet Fever	Diabetes	Additional Info: _____
Artificial Heart Valve	Thyroid Disease	_____
Heart Pacemaker	X-ray or Cobalt Treatment	_____
Heart Surgery	Chemotherapy(Cancer, Leukemia)	3._____
Artificial Joints (Knee, Hip)	Arthritis	_____
Anemia	Rheumatism	Additional Info: _____
Stroke	Cortisone Medication	_____
Kidney Trouble	Glaucoma	_____
Ulcers	Pain in Jaw Joints	4._____
Cosmetic Surgery	Cold Sores	_____
Sickle Cell Disease	Fever Blisters	Additional Info:_____
Hepatitis A (Infectious)	Hepatitis B (Serum)	_____
Liver Disease	Yellow Jaundice	_____
Blood Transfusion	Drug Addiction	5._____
Hemophilia	Venereal Disease (Syphilis, Gonorrhea)	_____
Epilepsy or Seizures	Herpes	Additional Info: _____
Fainting or Dizzy Spells	Nervousness	_____
ADD	Bruise Easily	_____
ADHD	Psychiatric Treatment	_____
Aspergers	Special Needs:	_____
Autism	_____	_____

IT IS IMPERATIVE THAT THE SECTIONS BELOW ARE COMPLETED!

DETAILED AND ACCURATE PATIENT AND FAMILY MEDICAL HEALTH HISTORY IS CRITICAL!

Are you immune suppressed? _____ yes _____ no
Have you ever-required long-term antibiotic therapy? _____ yes _____ no
Do you have frequent oral sores? _____ yes _____ no
Do you require steroid medications in conjunction with medical treatment? _____ yes _____ no

10. **Have you, the patient, ever been admitted to the hospital for any reason?** (i.e. broken bones, childbirth, etc.) List reason and date: _____
_____
_____
_____

11. **Have you, the patient, ever had surgery of any kind?** (i.e. appendectomy, previous oral surgery) Have you had any problems with a previous general anesthesia? (i.e. post operative nausea/vomiting, reaction to medication)
List procedure and date: _____
_____
_____
_____

12. In your **family medical history** (mother's or father's side of the family - up to the patient's grandparents) is there a history of major illness/disease? (i.e. heart attack or heart disease, high blood pressure, stroke, cancer, diabetes, etc.) List family member and illness/disease: _____
_____
_____
_____

13. FOR WOMEN ONLY:
Are you pregnant? _____ yes _____ no Due date? _____
Are you nursing? _____ yes _____ no
Are you taking birth control pills? _____ yes _____ no

THE ABOVE INFORMATION IS TRUE.

Patient/Guardian Signature:_____

CONSENT:

The undersigned hereby authorizes Dr. Duncan to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Duncan to make a thorough diagnosis of the patient's oral and maxillofacial needs. I also authorize Dr. Duncan to perform any and all forms of treatment, therapy and medication that may be indicated in connection with (Name of patient)_____
and further authorize and consent that Dr. Duncan choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

_____

(Signature of Patient, Parent, Guardian, or Responsible Party)

_____

(Please print name of Patient, Parent, Guardian or Responsible Party)

_____ _____

Date **Relationship to Patient**

Revised 11/2014