Anesthesia for Dentistry
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Adult Health History

PATIENT INFORMATION (CONFIDENTIAL) Today's Date_____

Name: _____Date of Birth: _____Age:_____

Address: _____City: _____State: _____Zip:_____

Home Phone: _____Cell#:_____Social Security #:_____

Fax #: _____email:_____Marital status:_____

Who to Contact in Case of Emergency: _____Phone #_____

RESPONSIBLE PARTY

Name of Person Responsible for the Account:_____

Relationship to Patient: _____Driver's License #:_____

Birth Date: _____Home Phone: _____Cell Phone/Pager:_____

Address: _____City: _____State: _____Zip:_____

Employer: _____Social Security #:_____

MEDICAL HISTORY

Have you ever had any of the following medical problems?

Y	N	Allergies to any drugs	Y	N	Diabetes	Y	N	Phen-Fen Use present/past
Y	N	Any Hospital Stays	Y	N	Seizures / Epilepsy	Y	N	Tuberculosis
Y	N	Any Operations	Y	N	Handicaps / Disabilities	Y	N	Heart Murmurs
Y	N	Latex Allergy	Y	N	Cancer	Y	N	Kidney Problems
Y	N	Bleeding Problems	Y	N	Rheumatic / Scarlet Fever	Y	N	Developmentally Delayed
Y	N	Hearing Impairments	Y	N	Heart Defects	Y	N	Cerebral Palsy
Y	N	Asthma / Lung Problems	Y	N	Hepatitis / Liver problems	Y	N	WOMEN: Is there any possibility you could be pregnant?

Weight_____ Height_____

Please discuss any medical problems that you have/had:_____

_____

_____

Physician: _____Phone Number:_____

Are you currently under the care of a physician: Yes__No__ Date of Last Visit: _____

Please describe your current physical health: Excellent _____Good_____Poor_____

Please list all medications you are currently taking:_____

_____

Please list any known Allergies, including allergies to medications: _____

_____

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform Dr. Rajeev Misra of any changes in my medical status at the earliest possible time.

Signature of Patient_____ Date _____

Reviewed by: _____ Date _____