HALF MOON

Oral Maxillofacial & Implant Surgery

LAST NAME (LEGAL) | FIRST NAME | SOCIAL SECURITY #

DATE OF BIRTH | GENDER | MAILING ADDRESS + CITY, STATE, ZIP CODE

CELL PHONE NUMBER | HOME PHONE NUMBER | EMAIL

RESPONSIBLE PARTY NAME (IF NOT PATIENT) | RESPONSIBLE PARTY DATE OF BIRTH | RESPONSIBLE PARTY SOCIAL SECURITY NUMBER

EMPLOYMENT OF RESPONSIBLE PARTY AND WORK PHONE NUMBER

PRIMARY DENTIST | PRIMARY PHYSICIAN | PHARMACY

EMERGENCY CONTACT

LAST NAME | FIRST NAME | DOB

RELATIONSHIP TO PATIENT | PHONE NUMBER

WHO MAY WE THANK FOR REFERRING YOU?

ALLERGIES

MEDICATIONS

FOOD

_ ACRYLIC
_ LATEX
_ METALS
_ LOCAL ANESTHETIC

CURRENT MEDICATIONS

SURGERIES AND HOSPITALIZATIONS

Health History

Patient Name: _____ **Date of Birth :** _____ **Height:** _____ **Weight:** _____

I. Circle the Appropriate Response

YES NO Is your general health good?
YES NO Has there been a change in your health in the last year?
YES NO Have you been hospitalized or had a serious illness in the last three years? If so, why?
YES NO Are you being treated by a physician now? For what?
Date of last medical exam: _____
Date of last dental exam: _____
YES NO Have you had problems with prior dental treatment?
YES NO Are you in pain now?

II. HAVE YOU EXPERIENCED:

YES NO Chest pain (angina)?
YES NO Swollen ankles?
YES NO Shortness of breath?
YES NO Recent weight loss, fever, night sweats?
YES NO Persistent cough, coughing blood?
YES NO Bleeding problems, bruising easily?
YES NO Sinus problems?
YES NO Frequent urination?
YES NO Dizziness?
YES NO Ringing in the ears?
YES NO Headaches?
YES NO Fainting spells?
YES NO Blurred vision?
YES NO Seizures?
YES NO Excessive thirst?
YES NO Diarrhea, constipation, blood in stools?
YES NO Frequent vomiting, nausea?
YES NO Difficulty urinating,blood in urine?
YES NO Dry mouth?
YES NO Jaundice?
YES NO Joint pain, stiffness?
YES NO Difficulty swallowing?

III. DO YOU HAVE OR HAVE YOU HAD:

YES NO Heart disease?
YES NO Heart attack?
YES NO Heart murmur, heart defects?
YES NO Rheumatic fever?
YES NO Stroke, hardening of the arteries?
YES NO High blood pressure?
YES NO Asthma, COPD, TB, emphysema?
YES NO Hepatitis, other liver disease?
YES NO HIV or AIDS
YES NO Herpes?
YES NO Arthritis, rheumatism?
YES NO Eye diseases?
YES NO Skin diseases?
YES NO Cancer, tumors?
YES NO Sleep Apnea?
YES NO Use a CPAP machine?
YES NO STD?
YES NO Anemia?
YES NO Thyroid, adrenal disease?
YES NO Stomach problems, ulcers?
YES NO Diabetes? (Type 1 or Type 2)
YES NO Kidney, bladder disease?
YES NO Family history of heart disease, diabetes, cancer/tumors?

IV. DO YOU HAVE OR HAVE YOU HAD?

YES NO Psychiatric care?
YES NO Dementia or Alzheimer's Disease?
YES NO Radiation?
YES NO Chemotherapy?
YES NO Hospitalization?
YES NO Blood transfusions?
YES NO Surgeries?
YES NO Pacemaker?
YES NO Prosthetic heart valve?
YES NO Artificial joint?
YES NO Contact lenses?

V. ARE YOU TAKING?

YES NO Recreational drugs?
YES NO Marijuana?
YES NO Tobacco in any form?
YES NO Alcohol?

VI. WOMEN ONLY:

YES NO Are you or could you be pregnant?
YES NO Nursing?
YES NO Taking birth control pills?

VII. ALL PATIENTS:

YES NO Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and or medication.

Patient Signature (parent/legal guardian if under 18): _____ Date: _____

Yearly Recall Review:
Patient Signature: _____ Date: _____
Patient Signature: _____ Date: _____
Patient Signature: _____ Date: _____