DENTAL ANESTHESIA ASSOCIATES

HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION (CONFIDENTIAL): Today's Date: _____

Name:_____ Date of Birth:_____ Age: _____

Nickname:_____ Sex: _____ Height:_____ Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone:_____ Email: _____

Name of Person Responsible (If patient is minor): _____ Relationship: _____

Home Phone: _____ Cell Phone:_____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

In the following questions circle YES or NO, which ever applies. Your answers remain strictly confidential.

1. Are you in good health?	YES	NO
2. Has there been any change in your general health within the past year?	YES	NO
3. My last physical was on_____	YES	NO
4. Are you now under the care of a physician?	YES	NO
If yes, what is the condition being treated? _____		
Name of physician_____ Phone_____		
5. Have you had any serious illness or operation that required hospitalization	YES	NO
If yes, what and when was the illness or operation_____		
6. Damaged heart valves or artificial heart valves?	YES	NO
7. Congenital heart defect(s) or murmur?	YES	NO
8. Cardiovascular disease: heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, or hypertension (high blood pressure)?	YES	NO
Do you have chest pain on exertion?	YES	NO
Are you ever short of breath after mild exercise?	YES	NO
Do your ankles swell?	YES	NO
Do you get short of breath when you lie down?	YES	NO
Do you have a cardiac pacemaker?	YES	NO
Do you have arrhythmia or irregular heartbeat?	YES	NO
9. Have you ever been told you need to take antibiotics prior to dental treatment?	YES	NO
10. Stroke?	YES	NO
11. Sinus Trouble?	YES	NO
12. Asthma?	YES	NO
13. Hay fever, hives, skin rash?	YES	NO
14. Seizures?	YES	NO
15. Diabetes?	YES	NO
16. Hepatitis, jaundice, or liver disease?	YES	NO
17. Arthritis or inflammatory rheumatism?	YES	NO
18. Stomach ulcers?	YES	NO
19. Esophageal reflux?	YES	NO
20. Kidney trouble?	YES	NO
21. Tuberculosis or persistent cough?	YES	NO
22. Low blood pressure?	YES	NO
23. Venereal disease?	YES	NO
24. Psychological treatment?	YES	NO

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25. Do you have a history of alcoholism or drug dependence?	YES	NO
26. Have you taken any recreational drugs in the past year such as cocaine, crack, marijuana?	YES	NO
If yes, what?_____ when? _____		
27. Do you smoke?	YES	NO
If yes, what?_____ when? _____		
28. On average how much alcohol do you drink per week? _____	YES	NO
29. Do you bleed easily, bruise easily or have had any abnormal bleeding after surgery?	YES	NO
30. Do you have blood disorders such as anemia?	YES	NO
31. Have you ever had surgery or x-ray treatment for a tumor, cyst, growth or other condition on your head or neck?	YES	NO
32. Are you allergic to any foods or medications?	YES	NO
If yes, please list and describe the reaction? _____		
33. Please list all medications that you are taking including over the counter and herbal medications: _____	YES	NO
34. Please list any surgeries or anesthetics you have had and the date: _____ _____	YES	NO
35. Has any blood relative had any bad reaction to any anesthetics?	YES	NO
36. Do you have any disease, condition or problem not listed?	YES	NO
37. Are you pregnant?	YES	NO
38. Do you have any problems associated with your menstrual period?	YES	NO
39. Are you a nursing mother?	YES	NO

I understand that withholding any information about my health could seriously jeopardize my safety. I have reviewed this health history carefully and answered all questions truthfully to the best of my knowledge.

Signature of patient or legal guardian _____

Date _____

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DENTAL ANESTHESIA ASSOCIATES

Date:

S: HPI:

ROS: HEENT:

Cardiac:

Pulm:

Liver/Kidney:

Endo:

Neuro:

Meds:

Aller:

Sx/Anest:

SH:

O: Gen: Wt: BP: HR: S pO2:

HEENT:

Heart :

Lungs:

A: ASA_____

P:

Signature_____

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