GREENWICH
ORAL AND MAXILLOFACIAL SURGERY
DENTAL IMPLANT SURGERY

DARIEN
ORAL SURGERY
DENTAL IMPLANT SURGERY

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TODAY'S DATE ____/____/____ **PLEASE PRINT**

PATIENT'S NAME	SEX	AGE	BIRTHDATE	OCCUPATION	HOME PHONE BUS. PHONE CELL PHONE
PATIENT'S ADDRESS		CITY		STATE	ZIP
RESPONSIBLE PARTY'S NAME	SOC. SEC. #				
RESPONSIBLE PARTY'S ADDRESS		CITY		STATE	ZIP
EMPLOYER (COMPANY NAME AND ADDRESS)		SPOUSE'S NAME		PHYSICIAN'S NAME	
REASON FOR VISIT HERE		REFERRED BY			
PREFERRED PHARMACY : NAME	ADDRESS			PHONE	

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N) ALL RESPONSES ARE KEPT CONFIDENTIAL

1. ARE YOU IN GOOD HEALTH? ..... Y N
2. HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR? ..... Y N
3. DATE OF LAST PHYSICAL EXAM? _____
4. ARE YOU NOW UNDER A PHYSICIAN'S CARE FOR A PARTICULAR PROBLEM? ..... Y N
   IF SO, WHAT FOR? _____
5. HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS OR HOSPITALIZATIONS? IF SO, DESCRIBE:
   _____
   _____
6. HAVE YOU HAD ANY ADVERSE EFFECTS FROM DENTAL TREATMENT? ..... Y N
7. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE? ..... Y N
   - B. CONGENITAL HEART DISEASE? ..... Y N
   - C. CARDIOVASCULAR DISEASE (HEART TROUBLE, HEART ATTACK, HEART MURMUR, CORONARY ARTERY DISEASE, ANGINA, HIGH BLOOD PRESSURE, STROKE, PALPITATIONS, HEART SURGERY, PACEMAKER)? ..... Y N
   - D. LUNG DISEASE (ASTHMA, EMPHYSEMA, CHRONIC COUGH, BRONCHITIS, PNEUMONIA, TUBERCULOSIS, SHORTNESS OF BREATH, CHEST PAIN, SEVERE COUGHING)? ..... Y N
   - E. SEIZURES, CONVULSIONS, EPILEPSY, FAINTING, PSYCHIATRIC TREATMENT, DIZZINESS, NERVOUS DISORDER OR BREAKDOWN? ..... Y N
   - F. BLEEDING DISORDER, ANEMIA, BLEEDING TENDENCY, BLOOD TRANSFUSION, DO YOU BRUISE EASILY? ..... Y N
   - G. LIVER DISEASE (JAUNDICE, HEPATITIS)? ..... Y N
   - H. KIDNEY DISEASE? ..... Y N
   - I. DIABETES? ..... Y N
   - J. THYROID DISEASE (GOITER)? ..... Y N
   - K. ARTHRITIS? ..... Y N
   - L. STOMACH ULCERS OR COLITIS? ..... Y N
   - M. GLAUCOMA? ..... Y N
   - N. FREQUENT OR RECURRING MOUTH SORES? ..... Y N
   - O. IMPLANTS PLACED ANYWHERE IN YOUR BODY (HEART VALVE, HIP, KNEE)? ..... Y N
   - P. RADIATION (X-RAY) TREATMENT FOR CANCER? ..... Y N
   - Q. CLICKING OR POPPING OF JAW JOINT, PAIN NEAR EAR, DIFFICULTY OPENING MOUTH, GRIND OR CLENCH TEETH? ..... Y N
   - R. SINUS OR NASAL PROBLEMS? ..... Y N
   - S. ANY DISEASE, DRUGS OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM? ..... Y N
   - T. RECURRENT INFECTIONS OF ANY KIND? ..... Y N
8. ARE YOU USING OR TAKING ANY OF THE FOLLOWING:
   - A. TAGAMET? ..... Y N
   - B. THYROID MEDICATIONS? ..... Y N
   - C. ANTIBIOTICS OR SULFA DRUGS? ..... Y N
   - D. ANTICOAGULANTS (BLOOD THINNERS)? ..... Y N
   - E. HIGH BLOOD PRESSURE MEDICINE? ..... Y N
   - F. STEROIDS (CORTISONE, ETC.)? ..... Y N
   - G. TRANQUILIZERS (VALIUM, ETC.)? ..... Y N
   - H. INSULIN, DIABENESE, OR SIMILAR DRUG? ..... Y N
   - I. DIGITALIS, INDERAL, NITROGLYCERIN, CALCIUM CHANNEL BLOCKERS, PROCARDIA OR OTHER HEART MEDICINE? ..... Y N
   - J. ASPIRIN OR IBUPROFEN (MOTRIN, NAPROSYN, ETC.)? HOW MUCH DAILY? _____ ..... Y N
   - K. MARIJUANA OR OTHER "STREET" DRUGS? ..... Y N
   - L. ANTIHISTAMINES OR DECONGESTANTS (SELDANE)? ..... Y N
   - M. ARE YOU TAKING ANY OTHER REGULAR MEDICATIONS, PILLS, OR DRUGS? ..... Y N

   IF YES, PLEASE LIST: _____
9. ARE YOU ALLERGIC OR HAD A BAD REACTION TO:
   - A. LOCAL ANESTHETIC (NOVOCAINE, ETC.)? ..... Y N
   - B. PENICILLIN, AMOXICILLIN, CEPHALOSPORINS OR OTHER ANTIBIOTICS? ..... Y N
   - C. BARBITURATES, SEDATIVES, ETC.? ..... Y N
   - D. ASPIRIN OR IBUPROFEN? ..... Y N
   - E. CODEINE OR OTHER PAIN KILLERS? ..... Y N
   - F. LATEX OR RUBBER PRODUCTS? ..... Y N
   - G. OTHER ALLERGIES OR REACTIONS? ..... Y N

   IF YES, PLEASE LIST: _____
   _____
10. DO YOU SMOKE OR CHEW TOBACCO? ..... Y N
    HOW MUCH DAILY? _____
11. DO YOU USE ALCOHOL? ..... Y N
    HOW MUCH? _____
12. HAVE YOU EVER SOUGHT PROFESSIONAL CARE FOR DRUG ABUSE, ALCOHOLISM OR EMOTIONAL DISORDERS? ..... Y N
13. WOMEN: ARE YOU PREGNANT OR PLANNING PREGNANCY? ... Y N
    ARE YOU TAKING BIRTH CONTROL PILLS? ..... Y N
    ARE YOU TAKING HORMONE REPLACEMENTS? ..... Y N
14. DO YOU HAVE ANY OTHER DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT? ..... Y N
15. DO YOU WISH TO TALK WITH THE DOCTOR PRIVATELY ABOUT ANYTHING? ..... Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE.

_____ /_____
SIGNATURE OF PERSON COMPLETING HEALTH HISTORY — DR'S INITIALS

MEDICAL UPDATE: I HAVE READ MY HEALTH HISTORY DATED ____/____/____ AND CONFIRM THAT IT ADEQUATELY STATES PAST AND PRESENT CONDITIONS.

DATE _____ EXCEPTIONS OR CHANGES _____ PATIENT'S SIGNATURE _____ DOCTOR'S INITIALS _____