

Green Mountain Sedation & General Dentistry

118 Tilley Drive, Suite 101
So. Burlington, VT 05403

For Office Use ASA: _____

Health History

Date: _____

Name: _____

Date of Birth: _____

Have you been hospitalized in the last 5 years? (circle one) **No** **Yes**

If yes, reason: _____

Have you had any complications following dental treatment? **NO** **YES-explain:** _____

Are you now under the care of a physician? **No** If yes, nature of care: _____

Please list the names and phone numbers of the physicians who are currently providing you care:

Please circle or note any medication you are allergic to or had a reaction to:

Local anesthetic: _____

Penicillin or other antibiotics: _____

Aspirin, Ibuprofen or Tylenol: _____

Codeine, Valium or other sedatives: _____

Latex or Metals: _____

Other (please specify): _____

Please list any medications you are currently taking and dosages:

MEDICATIONS:	DOSE:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any dietary or herbal supplements, and for what purpose?:

Women: Are you pregnant?	NO	YES
If no, are you planning a pregnancy in the near future?	NO	YES
Are you a nursing mother?	NO	YES
Are you taking birth control pills?	NO	YES

Abnormal Blood Pressure (please circle)			
Have you ever received a diagnosis of "high blood pressure"?		NO	YES
What is your normal blood pressure?	S	/D	Today: /

For the following questions please circle Yes or No:

Anemia or Blood Disorder?	NO	YES	Hepatitis, Any Form	NO	YES
Arthritis, Rheumatism or other inflammatory disease?	NO	YES	Joint Replacement? When Placed?	NO	YES
Asthma	NO	YES	Kidney Disease	NO	YES
Abnormal Bleeding from a cut?	NO	YES	Liver Disease	NO	YES
Cancer or Tumor?	NO	YES	Sore/Enlarged Lymph Nodes	NO	YES
Diabetes	NO	YES	Psychosis	NO	YES
Emphysema or other Respiratory/Lung Illnesses	NO	YES	Previous Biopsies	NO	YES
Epilepsy	NO	YES	Radiation or Chemotherapy Treatment	NO	YES
Fainting or Dizzy Spells	NO	YES	Rheumatic Fever	NO	YES
Glaucoma	NO	YES	Slow-Healing Mouth Sores	NO	YES
Abnormal Heart or Previous Bacterial Endocarditic	NO	YES	Unintentional Weight Loss/Gain	NO	YES
Heart Valve (artificial) or Heart Transplant	NO	YES	H.I.V. Infection/AIDS or ARC	NO	YES
Congenital Heart Disease	NO	YES	Venereal Disease	NO	YES
Heart Disease, Heart Attack, Heart Surgery	NO	YES	Other Conditions	NO	YES
Heart Stent? When Placed?	NO	YES	Recurrent Illnesses	NO	YES
			Sleep Apnea	No	YES

Are you taking any of these medications?

Pre-Medication before dental care?	NO	YES	(omeprazole)?	NO	YES
Antacids?	NO	YES	(Verapamil)?	NO	YES
Ditantin® or Tegretol®	NO	YES	Serzone® (nefazodone)	NO	YES
Barbiturates (any)	NO	YES	(itraconazole)	NO	YES
St. John's Wort or Kava-Kava	NO	YES	Biaxin® (clarithromycin)	NO	YES
Have you ever taken prescription drugs such as fen-phen for weight loss?				NO	YES
Do you consume grapefruit juice, grapefruits or grapefruit extract?				NO	YES

Tobacco, Alcohol, Drugs:

Do you use tobacco? If yes, circle type: <u>Smoke</u> <u>Chew</u> How much per day? For how long?	NO	YES
Do you want to quit using tobacco?	NO	YES
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	NO	YES
Do you use any mood altering drugs other than those previously listed?	NO	YES

Sugar in your diet (circle one): None Slight Moderate High

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in health and medication.

Patient (Print Name)

Patient Signature

Date

Doctor Signature

Date