Drs. Elrod, Green & Hyland, DDS

Health History for Conscious Sedation Patients

Patient Name:_____

Date of last health care exam:_____ What was this exam for?_____
Have you been hospitalized in the last 5 years? (Please circle) No Yes
_____

Are you currently receiving care: No Yes
If yes, nature of care: _____

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

1. _____
2. _____

For the following questions circle No or Yes. Your answers are for our records only & will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No Yes	Psychosis	No Yes
Anemia	No Yes	Sore-Enlarged Lymph Nodes	No Yes
Diabetes	No Yes	Previous Biopsies	No Yes
Epilepsy	No Yes	Slow-Healing Mouth Sores	No Yes
Hepatitis, any form	No Yes	Other Infections	No Yes
Rheumatic Fever	No Yes	Recurrent Illnesses	No Yes
Asthma	No Yes	Joint Replacement	No Yes
HIV Positive/AIDS Related Complex	No Yes	Glaucoma	No Yes
Emphysema or other Respiratory Illnesses	No Yes	Abnormal Bleeding from a cut	No Yes
Abnormal Heart Condition	No Yes	Liver Disease/Jaundice	No Yes
Kidney Disease	No Yes	Unintentional Weight Loss/Gain	No Yes
Heart (Surgery, Disease, Attack)	No Yes	Latex Sensitivity	No Yes
Venereal Disease	No Yes	HIV Infections/AIDS	No Yes

Are you required to Pre-Medicate before dental treatment No Yes

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) No Yes

If yes, what is it usually: S_____/D_____

Are you allergic or have you had a reaction to:

A. Local anesthetics . . . . . No Yes
B. Penicillin or other antibiotics . . . . . No Yes
C. Aspirin . . . . . No Yes
D. Codeine, valium or other sedatives . . . . . No Yes
E. Other _____

Are you a smoker? No Yes

If so, how much do you smoke per day? _____

Do you have sleep apnea? . . . . . No Yes
Does your family hear you sleeping? . . . . . No Yes

Do you consume grapefruit juice, grapefruits or grapefruit extract? . . . . . No Yes

Please list any medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? _____

Do you take Antacids? No Yes If yes, how often? _____

Are you taking any herbal supplements/medicines? No Yes

If yes, which ones _____

Weight: _____

Diet:

Restricted Diet: _____
How many meals a day _____
Food Allergies _____

Sugar in your diet None ____ Slight ____ Moderate ____ High ____