Oral & Facial Surgery Center

Robin C. Ardoin, D.D.S., Ph.D.

Harold D. Kennedy, D.D.S.

HEALTH HISTORY

For Office Use Only - Do Not Write in This Space

Patient _____ **Referral** _____ **Date** _____

BP _____ **Pulse** _____ **Resp** _____ **Age** _____ **Wt** _____

C.C.-

Allergies **Meds** **Medical Problem List**

1) **Have you been hospitalized or had any serious illness in the past five years? Yes** _____ **No** _____
If Yes, explain: _____.

2) **The Name of your medical doctor is** _____.

3) **Please circle any of the following conditions which you have had:**

Heart Trouble	Diabetes	Cancer
Damaged Heart Valve/ Mitral Valve Prolapse	Glaucoma	Radiation Treatment
	Anemia	Venereal Disease
Heart Murmur	Asthma	HIV/AIDS
Chest Pain	Emphysema	Alcohol/Drug Abuse
Heart Attack	Tuberculosis	Anesthesia Problems
Pacemaker	Stroke	Stomach Ulcers
High Blood Pressure	Seizures	Hepatitis
Kidney Problems/Dialysis	Fainting Spells	Arthritis

4) **Do you smoke? Yes** ___ **No** ___

5) **If there are any medical problems not listed that you think we should know, please explain:** _____
_____.

WOMEN ONLY:

6) **Is there any chance that you are pregnant? Yes** ___ **No** ___ **Not Sure** ___

7) **Any elective surgery and anesthesia during pregnancy is potentially harmful to the developing fetus. You have the option of consulting with your physician to rule out pregnancy before your surgical procedure. Do you wish to consult with your physician about the possibility of pregnancy prior to scheduling your surgery?**
Yes ___ **No** ____

X_____

Signature of Patient (or parent if patient is a minor)