

Patient Information Form

1 PATIENT INFORMATION

Name Mr. Mrs. Ms. Dr. _____ Date of Birth _____ Age _____
_____ Weight _____ Height _____
Address _____ City _____ State _____ Zip _____
Phone # _____ Business # _____ Cell # _____
Employment _____ Soc. Sec. # _____
Mother's Name (if Under 18) _____ Mother's Work # _____
Mother's Address _____ City _____ State _____ Zip _____
Mother's Employer _____
Father's Name (if Under 18) _____ Father's Work # _____
Father's Address _____ City _____ State _____ Zip _____
Father's Employer _____
Dentist's Name _____ Orthodontist's Name _____
Physician's Name _____ Physician's # _____
Please List all Other Treating Physician's _____

Pharmacy Name _____ Pharmacy # _____
Who can We Thank for Referring You? _____

2 MEDICAL HISTORY (For Your Health's Sake, You Must be Accurate)

PLEASE CHECK

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joint
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimers

CONTINUE MEDICAL HISTORY ON BACK ►

YES NO

- 1. Are you having pain or discomfort at this time? YES NO
- 2. Do you feel extremely nervous about having oral surgery? YES NO
- 3. Have you ever had a bad experience in a dental office? YES NO
- 4. Have you been a patient in a hospital during the last year? YES NO
- 5. Have you ever had any excessive bleeding requiring special treatment? YES NO
- 6. If you answered yes to question 1 - 5, please explain briefly _____

7. Are you allergic to or made sick by any drugs or medication? Please list _____

8. Are you taking any medicine or drugs now? Please list _____

9. Do you have an allergy to latex? If Yes, what type of symptoms do you have? _____

10. Do you have any disease, condition, or problem not listed you think the doctor should know about? _____

11. Has any other member of your family been treated by Dr. Lee? Please List _____

12. Are you pregnant now? YES NO

13. Do you have any history of motion sickness? YES NO

14. Have you ever had a general anesthetic? YES NO

15. Do your ankles swell during the day? YES NO

16. Do you wear contact lenses? YES NO

17. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath? YES NO

18. Please list any complications you have experienced from general anesthesia or intravenous sedation? _____

19. Have you or any blood relative ever had a problem waking up from general anesthesia? If yes, please explain.

20. Have you ever had a sleep study? If Yes, what facility performed the study? _____

21. Have you ever been treated with C-PAP for obstructive sleep apnea? YES NO

22. Do you use tobacco? Amount per day? _____

To the best of my knowledge, all of the preceding answers are true and correct. I will inform my doctor of changes

3 YOUR SIGNATURE _____ DATE _____

PARENT OR GUARDIAN _____ DATE _____