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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	
☐	☐	Heart Failure	☐	☐	Emphysema	☐	☐	Kidney Trouble
☐	☐	Heart Attack	☐	☐	Chronic Bronchitis	☐	☐	AIDS
☐	☐	Chest Pain	☐	☐	Tuberculosis (TB)	☐	☐	Hepatitis
☐	☐	High Blood Pressure	☐	☐	Asthma	☐	☐	Liver Disease
☐	☐	Heart Murmur	☐	☐	Hay Fever	☐	☐	Blood Transfusion
☐	☐	Rheumatic Fever	☐	☐	Cancer	☐	☐	Drug or Alcohol Abuse
☐	☐	Artificial Heart Valve	☐	☐	Diabetes	☐	☐	Hemophilia
☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Disease	☐	☐	Epilepsy or Seizures
☐	☐	Heart Pacemaker	☐	☐	Chemotherapy	☐	☐	Psychiatric Treatment
☐	☐	Heart Surgery	☐	☐	Cancer, Leukemia	☐	☐	Bruise Easily
☐	☐	Artificial Joint	☐	☐	Arthritis	☐	☐	Ulcers
☐	☐	Stroke	☐	☐	Glaucoma	☐	☐	Pain in Jaw Joint
☐	☐	Sleep Apnea	☐	☐	Osteoporosis	☐	☐	Alzheimers

CONTINUE MEDICAL HISTORY ON BACK ▶

	YES	NO
1. Are you having pain or discomfort at this time?	☐	☐
2. Do you feel extremely nervous about having oral surgery?	☐	☐
3. Have you ever had a bad experience in a dental office?	☐	☐
4. Have you been a patient in a hospital during the last year?	☐	☐
5. Have you ever had any excessive bleeding requiring special treatment?	☐	☐

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?	☐	☐
13. Do you have any history of motion sickness?	☐	☐
14. Have you ever had a general anesthetic?	☐	☐
15. Do your ankles swell during the day?	☐	☐
16. Do you wear contact lenses?	☐	☐
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?	☐	☐

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? ☐ ☐

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

YOUR SIGNATURE _____ **DATE** _____

PARENT OR GUARDIAN _____ **DATE** _____