MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAD:

___ALLERGIES (SEASONAL)
___ADHD
___ANEMIA
___ANGINA PECTORIS
___ARTIFICIAL HEART VALVE
___ARTIFICIAL JOINT (HIP,KNEE)
___ASTHMA
___AUTISM
___BLEEDING ABNORMALLY
___CANCER
___RADIATION
___CHEMOTHERAPY
___CHEMICAL DEPENDENCY
___CONGENITAL HEART LESION
___CORTISONE MEDICINE
___DEPRESSION
___DIABETES (insulin Y☐ N☐)
___EMPHYSEMA

___ EPILEPSY OR SEIZURES
___GLAUCOMA
___HEART FAILURE
___HEART DISEASE OR ATTACK
___ HEART MURMUR
___HEART PACEMAKER
___HEART SURGERY
___HEMOPHILIA
___HEPATITIS A
___HEPATITIS B
___HEPATITIS C
___HIGH BLOOD PRESSURE
___HIV POSITIVE
___KIDNEY DISEASE

___OTHER_____

___LIVER DISEASE
___MITRAL VALVE PROLAPSE
___PAIN IN JAW JOINTS
___OSTEOPOROSIS
___SICKLE CELL ANEMIA
___SLEEP APNEA
___STROKE
___SWOLLEN NECK GLANDS
___THYROID PROBLEMS
____TOBACCO or ALCOHOL USE

Women Only:

Are you pregnant or anticipating becoming pregnant? Y☐ N☐
Due Date : _____

MEDICATIONS

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING OVER THE COUNTER MEDICATIONS:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

LIST ANY OTHER SERIOUS DISEASE/ ILLNESS/INJURY: _____

LIST PREVIOUS PROBLEMS WITH EXTRACTIONS OR SURGERIES: _____

HAVE YOU BEEN HOSPITALIZED WITHIN THE LAST FIVE YEARS?: _____

ALLERGIES

___ASPIRIN ___ACHROMYCIN ___CODEINE ___MORPHINE ___IODINE ___PENICILLIN ___LATEX ___SULFA

___TETRACYCLINE OTHER: _____

I understand the above information is necessary to provide me with oral surgery care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I will not hold Dr. Cowan or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

The undersigned hereby authorizes Dr. Cowan to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Cowan to make a thorough diagnosis of the patient's oral surgery needs.

X_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE