FLORIDA DENTAL ANESTHESIA SERVICES, LLC. • TEL: 786.486.3392 • INFO@FLORIDADENTALANESTHESIA.COM

Health History (Adult)

PATIENT INFORMATION (confidential)

Name: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____

RESPONSIBLE PARTY (if applicable)

Name of person responsible for account: _____ Relationship to Patient: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PAST MEDICAL HISTORY

Do you now, or have ever had (please check all that apply):

- ☐ Poor reaction to anesthesia
- ☐ Diabetes
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Hearing Impairments
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Goiter
- ☐ Cancer (type: _____)
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Heart Problems
- ☐ Angina
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Shunts
- ☐ Chronic Cough
- ☐ Post Nasal Drip
- ☐ Epilepsy
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Cataracts
- ☐ Handicaps or Disabilities
- ☐ Cerebral Palsy
- ☐ Developmentally Delayed/Impaired
- ☐ Down Syndrome
- ☐ Sleep Apnea
- ☐ Clotting Problems
- ☐ Bleeding Problems
- ☐ Anemia
- ☐ Hepatitis
- ☐ Acid Reflux
- ☐ Stomach/Peptic Ulcer
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Shingles
- ☐ Enlarged Prostate (Men)
- ☐ Mastectomy (Women)
- ☐ Genetic Conditions

Please list any other medical problems you currently have, or have had in the past:

_____

_____

Office Use Only:

Patient Name:_____

Name of dentist performing procedure:_____

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Health History (Adult)

Please list all medications and dosages you are currently taking:

_____

_____

Please circle Yes (Y) or No (N) for the following questions:

Do you have any allergies to any foods and/or medications? Y N

If yes, please list: _____

What was the reaction experienced? _____

_____

Have you been hospitalized for any reason? Y N

If yes, when and for how long? _____

Have you had any surgeries? Y N

If yes, how long ago? _____

Do you smoke? Y N

If yes, how frequently? _____

Do you use any illicit drugs? Y N

If yes, please list which drugs and how frequently: _____

Do you drink alcohol? Y N

If yes, how often and how much: _____

WOMEN: Is there a possibility you could be pregnant? Y N

WOMEN: Are you nursing? Y N

The information on this questionnaire is accurate to the best of my knowledge.

Signature of Patient or Legal Guardian_____ Date_____

Print Name_____

Office Use Only:

Patient Name:_____

Name of dentist performing procedure:_____