BERKS ORAL SURGERY
+ DENTAL IMPLANT CENTER

PATIENT'S NAME _____ DATE _____

HEIGHT _____ WEIGHT _____ AGE _____

MEDICAL HISTORY AND HEALTH QUESTIONNAIRE

1. Are you in good health?	YES NO	f. NERVOUS DISORDER	YES NO
2. Are you now under the care of a physician?	YES NO	Stroke	YES NO
If so, for what condition?		Seizure	YES NO
3. Are you taking any prescription,	YES NO	Epilepsy	YES NO
non-prescription or herbal medications?		Headaches	YES NO
4. Are you allergic to:		Psychiatric care	YES NO
a. Any drugs or medications	YES NO	g. BLOOD DISORDER	YES NO
b. Local anesthesia (Novacaine, etc)	YES NO	Anemia	YES NO
c. Latex or rubber products	YES NO	Bleeding problems	YES NO
d. Soybeans or soy products	YES NO	Bleed/Bruise easily	YES NO
5. Have you ever had any operations?	YES NO	h. KIDNEY DISEASE	YES NO
6. Have you ever received general anesthesia?	YES NO	Dialysis treatment	YES NO
If yes, did you have any adverse reactions?	YES NO	i. LIVER DISEASE	YES NO
7. WOMEN- Are you pregnant or nursing?	YES NO	Hepatitis	YES NO
8. Do you smoke?	YES NO	j. IMMUNE SYSTEM	YES NO
If so, how much per day?		HIV/AIDS	YES NO
9. Do you drink alcohol?	YES NO	Organ transplant	YES NO
If so, how often?		k. SINUS DISEASE	YES NO
10. Do you wear contact lens?	YES NO	l. VENEREAL DISEASE	YES NO
11. Have you received radiation or chemotherapy?	YES NO	m. BONE DISEASE	YES NO
12. Do you have a history of bleeding problems?	YES NO	Osteoporosis	YES NO
13. **HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR:**		Medications for Osteoporosis, including: Bisphosphonate(Fosomax,Boniva,Zometa, Actonel, Aredia, Risedronate,Reclast)	YES NO
a. HEART TROUBLE	YES NO		
Congenital heart disease	YES NO		
Angina (chest pain)	YES NO	Artificial joint replacement	YES NO
Heart attack	YES NO	Back or neck injury	YES NO
Heart surgery	YES NO	Arthritis	YES NO
Pacemaker	YES NO	TMJ or jaw problems	YES NO
Damaged heart valve or heart murmur	YES NO	14. Have you been told by your physician that you are at risk for sudden cardiac arrest syndrome/ prolonged QT syndrome?	YES NO
High blood pressure	YES NO		
b. LUNG DISEASE	YES NO		
Asthma	YES NO	15. Has anyone in your family died under the age of 50 due to an unknown cause?	YES NO
Chronic bronchitis	YES NO		
Emphysema	YES NO	16. Do you suffer from lightheadedness/dizziness	YES NO
Shortness of breath	YES NO	17. Have you ever used recreational or street drugs?	YES NO
Tuberculosis	YES NO		
c. DIABETES	YES NO	18. Do you have a disease/condition not listed? If yes, please list	YES NO
d. THYROID DISEASE	YES NO		
e. SLEEP APNEA	YES NO	19. Do you wish to talk to the doctor privately?	YES NO

I understand the importance of a truthful history to assist the doctor in providing the safest care possible.

Person completing health history _____

Relationship to patient _____

Signature _____

DO NOT FILL OUT THIS SIDE

FOR OFFICE USE ONLY

PAST MEDICAL HISTORY

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SURGICAL HISTORY

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MEDICATIONS		ALLERGIES

MEDICAL HISTORY UPDATE

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