FRASER VALLEY DENTAL SPECIALISTS

ORAL SURGERY MEDICAL HISTORY

First Name: Last Name:

1. Is your physician treating you for a medical problem? YES ☐ NO ☐
   If yes, what condition(s) is being treated?
   _____

2. Have you had an operation? YES ☐ NO ☐
   Have been hospitalized? YES ☐ NO ☐
   If yes, please list the type and date:
   _____
   Were there problems with the sedation or general anesthetic? YES ☐ NO ☐
   If yes, please list the type and date:
   _____

3. Do you have, or had any of the following?

☐ Asthma	☐ Heart attack	☐ Angina/Chest Pain
☐ Bronchitis	☐ Stroke	☐ High/Low Blood Pressure
☐ Depression	☐ Ulcer	☐ Hepatitis/Jaundice
☐ Tuberculosis	☐ Anemia	☐ Alcohol or Drug Abuse
☐ Seizures	☐ Kidney Problems	☐ Liver Disease
☐ Arthritis	☐ Rheumatic Fever	☐ Mental/Nervous Disorder
☐ Cancer	☐ Thyroid Disorder	☐ Abnormal Bleeding
☐ Diabetes	☐ Immune Deficiency	☐ Radiation Therapy
☐ Glaucoma	☐ Heart Murmur	☐ HIV/AIDS

4. Do you have any other medical conditions not listed here that you believe Dr. Dahlman should know about? YES ☐ NO ☐ If yes, please describe:
   _____

5. Do you smoke? YES ☐ NO ☐ How many per day? _____ How many years? _____

6. Women: Are you pregnant? YES ☐ NO ☐ How many months? _____
   Are you breast-feeding? YES ☐ NO ☐

7. Have you ever had an allergic reaction to medication(s) including Latex? YES ☐ NO ☐
   If yes, which medication(s) and what reaction?
   _____

8. Are you presently taking any medications? YES ☐ NO ☐
   If yes, select the following that apply:

☐ Pain pills	☐ Birth Control	☐ Blood Thinners
☐ Heart pills	☐ Inhalers	☐ Insulin
☐ Aspirin	☐ Antibiotics	☐ Steroids/Cortisone
☐ Blood Pressure pills	☐ Antidepressants	☐ Other _____

Height:_____ Weight:_____

Signature: _____ PHN: Date: _____

Patient or Parent/Legal Guardian

PLEASE SUBMIT FORM