

SURGICAL HISTORY

Please list all previous operations.

Year	Procedure	Year	Procedure

Did you have any problems associated with anesthesia? YES NO

If yes, explain: _____

Did you have any unusual bleeding following surgery or injury? YES NO

If yes, explain: _____

Did you have abnormal scarring after surgery? YES NO

If yes, explain: _____

Did you have normal recovery following previous surgery? YES NO

If no, explain: _____

MEDICATION HISTORY

Please list all medications you are taking:

Medication	Reason for taking medication

Have you ever been on cortisone? YES NO

If yes, explain: _____

Have you ever had any allergic or unusual reactions to any medications? YES NO

If yes, explain: _____

SOCIAL HISTORY

Do you drink more than 4 cups of coffee per day? YES NO If yes, how many? _____

Do you have more than 2 alcoholic drinks in a day? YES NO If yes, how many? _____

Do you smoke? YES NO If yes, how much per day? _____

Do you use any recreational drugs? YES NO

FAMILY HISTORY

Age	Condition of health/cause of death	Is there a history of any of the following conditions in your family, if so, who?		
Mother		Allergies or asthma	Yes No	_____
Father		Bleeding tendencies	Yes No	_____
Brother		Cancer	Yes No	_____
Sister		Congenital defect	Yes No	_____
		Diabetes	Yes No	_____
		Epilepsy	Yes No	_____
		Heart attacks	Yes No	_____
		High blood pressure	Yes No	_____
		Psychiatric disorders	Yes No	_____
		Stomach trouble	Yes No	_____
		Strokes	Yes No	_____
		Tuberculosis	Yes No	_____

Do you have any physical handicaps? YES NO

If yes, explain: _____

Do you wear contact lens? YES NO

Do you wear partial dentures? YES NO UPPER LOWER

Do you wear complete dentures? YES NO

Do you use a hearing aid? YES NO

Do you have any medical problems not included in this form? YES NO

If yes, explain: _____

How would you describe your general health and state of mind? _____

Signature: _____