JOSEPH M. CATALANO, D.D.S., P.C.

Oral Surgery and Implantology

HEALTH HISTORY

Patient's Name:_____Date:_____

Patient Date of Birth: _____ Height: _____ Weight: _____

Please circle yes or no, whichever applies. Your answers are for our record only and will be confidential. Please make sure that everything is filled out completely.

1. Have there been any changes in your general health in the last year?.....Yes/No
2. When was your last physical examination?_____Physician's Name:_____Phone:_____
3. Are you now under the care of a physician?.....Yes/No
   If so, what is the condition being treated?_____
4. Have you had any serious illness requiring hospitalization?.....Yes/No
5. Please list past surgical history:_____
6. Have you had any serious problems associated with general anesthesia or sedation?.....Yes/No
   If so please explain:_____
7. a. Have you had any problems associated with previous dental treatment?.....Yes/No
   If so, please explain:_____
   b. Does your jaw joint (TMJ) pop click, lock, or cause pain?.....Yes/No
8. Do you have any of the following diseases or problems?
   a. Heart Murmur or Rheumatic heart disease.....Yes/No
   b. Heart valve replacement.....Yes/No
   c. Do you have prosthetic or artificial joints.....Yes/No
   d. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, angina, stroke).....Yes/No
   e. High blood pressure or hypertension.....Yes/No
   f. Asthma, bronchitis, TB, or emphysema.....Yes/No
   g. Fainting spells or seizures.....Yes/No
   h. Diabetes.....Yes/No
   i. Hepatitis, jaundice, or liver disease.....Yes/ No
   j. Bleeding disorders, prolonged bleeding, difficulty clotting or easy bruising.....Yes/No
   k. HIV.....Yes/No
   l. Arthritis or rheumatism.....Yes/No
   m. Stomach ulcers.....Yes/No
   n. Kidney trouble.....Yes/No
   o. Do you have any disease, condition, or problems not listed that you think I should know about?...Yes/No
   If so, please explain:_____
9. Do you smoke or use other tobacco products?..... Yes/No
10. Are you currently taking any prescription or over the counter medicine/supplements?.....Yes/No
    Please list type or dose:_____
    _____
11. **Are you allergic to or have reacted adversely to any drug or latex? (rash, itching, swelling, difficulty breathing)**_____. Yes/No

12. Are you now or have you ever been treated with **oral or intravenous bisphosphonates** for Osteoporosis/ Osteopenia/ Arthritis/ Cancer Bone Metastases? **Failure of disclosure can lead to complications in healing (osteonecrosis of the jaw) Oral forms:** Fosamax, Actonel, Skelid, Didronel, Boniva **Intravenous forms:** Zometa, Aredia..... .....Yes/No

Please read and initial the following statements, and sign when completed.

____1. **Drug or Alcohol Abuse:**

Do you have a history of social drug use?.....Yes / No
Recreational drug use, overdose with medication, or excessive alcohol consumption can adversely affect the liver function which is critical for producing blood clotting factors. Disclosure will allow your surgeon to safely treat you and prevent excessive post-surgical bleeding that can be life-threatening. Current Recreational Drug Use: Interaction with local anesthesia and IV sedation agents can be life threatening. Full disclosure is critical for safe management.

Women

____2. Is there any reason to suspect you may be pregnant?.....Yes / No

Pregnancy: I understand that if there is a possibility of current pregnancy, I will complete a home pregnancy test prior to scheduling an IV Sedation / general anesthetic procedure and report the results to my treating surgeon. Medications used during the surgery and post-operative period can adversely affect the developing baby.

____3. Do you have a problem associated with your menstrual cycle?.....Yes / No

____4. Are you on birth control medication?.....Yes / No

Birth Control Pills: Antibiotics are commonly prescribed during your surgical management. Antibiotics can decrease the efficacy of birth control pill leading to pregnancy. It is recommended that a second alternative form of birth control be used for one full cycle (month) if pregnancy is not desired.

The above history is true to the best of my knowledge.

Patient's signature:_____ Date:_____