Adult Health History

Barry Krall DDS Anesthesia For Dentistry

PATIENT INFORMATION (CONFIDENTIAL) Today's Date

Name: Birth Date: Age:

Address: City: State: Zip:

Home/Cell Phone: Email: (optional) .

Emergency contact: Phone: .

MEDICAL HISTORY

1. Height: Weight:
2. Are you currently under the care of a physician for a specific condition? Yes No
3. Date of last physical exam? .
4. Date of last cold, cough or fever? .
5. Please describe your current physical health (Circle One): Good Fair Poor
6. Please describe your routine physical activity level (Circle One): None low moderate high
7. Do you experience shortness of breath? (Circle One): At rest minimal exertion moderate exertion
8. Has there been any change in your health in the last year? Yes No
9. Have you had any recent hospitalizations or surgeries? Yes No
   a. If yes, when and why
10. Do you have cardiovascular disease? Yes No
    a. If yes, circle- arrhythmia, chest pain, coronary artery disease, heart attack, heart failure, heart valve disease/replacement, hypertension, pacemaker/defibrillator, stents
    Other:
11. Do you have pulmonary disease or symptoms? Yes No
    a. If yes, circle- asthma, bronchitis, emphysema, persistent cough, tuberculosis, wheezing
    Other:
12. Have you ever been diagnosed with sleep apnea? Yes No
13. Have you ever had any of the following medical problems?
    a. Arthritis
    b. Bleeding Problems / Bruise easily
    c. Blood disorder
    d. Cancer
    e. Diabetes
    f. Fainting episodes
    g. Hepatitis / Liver problems
    h. Kidney Problems
    i. Muscle weakness
    j. Seizures / Epilepsy
    k. Stroke
    l. Other

11. WOMEN: Is there any possibility that you could be pregnant? Yes No
12. Please list all medications you are currently taking: .
    .
13. Please list all allergies to medication or food: .
14. Do you smoke? If yes- how long? Packs/day? Yes No
15. Do you drink alcohol? If yes, how much? Yes No
16. Do you use recreational drugs? If so, what drug and when? Yes No
17. Have you or a close relative ever had a bad reaction to any anesthetic drug? Yes No
14. Has anyone in your family been diagnosed with malignant hyperthermia? Yes No
18. Have you ever had complications during a previous anesthetic? Yes No
19. What is your anxiety level related to dental treatment? Mild Moderate Severe

The information on this questionnaire is accurate to the best of my knowledge and that withholding any information could result in injury or death. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform Dr. Barry Krall of any changes in my medical status at the earliest possible time.

Signature of Patient Date .

Reviewed by: Barry Krall, DDS Date .