Central Houston
Oral & Implant Surgery
Dr. Phillip A. Kattchee DDS, PA

Health History

Patient's Name: _____Date: _____

Answer all questions by checking Yes (Y) or No (N). All responses are kept confidential.

1.	Are you in good health?	Yes	No
2.	Has there been any change in your general health in the past year?	Yes	No
3.	Date of last physical exam? _____		
4.	Are you now under a physician's care for a particular problem? If so describe	Yes	No

_____

_____

Name of Physician: _____

Address: _____

Telephone Number: _____

5.	Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe	Yes	No

_____

_____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**

A.	Rheumatic Fever or Rheumatic Heart Disease?	Yes	No
B.	Congenital Heart Disease?	Yes	No
C.	Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease Angina, High Blood Pressure, Stroke, Palpations, Heart Surgery, Pacemaker?)	Yes	No
D.	Lung Disease (Asthma, Emphysema, Chronic Cough Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing?	Yes	No
E.	Seizures, Convulsions, Epilepsy, Fainting, Dizziness Psychiatric Treatment, or other Nervous Disorder?	Yes	No
F.	Bleeding Disorder, Anemia, Bleeding Tendency,		

	Blood Transfusion? Do you bruise easily?	Yes	No
G.	Liver Disease (Jaundice, Hepatitis?)	Yes	No
H.	Kidney Disease?	Yes	No
I.	Diabetes?	Yes	No
J.	Thyroid Disease (Goiter)?	Yes	No
K.	Arthritis?	Yes	No
L.	Stomach Ulcers or Colitis?	Yes	No
M.	Glaucoma?	Yes	No
N.	Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?	Yes	No
O.	Radiation (X-ray) treatment for Cancer?	Yes	No
P.	Clicking or popping of jaw joint, pain near ear difficulty opening mouth, grind or clench teeth?	Yes	No
Q.	Sinus or Nasal Problems?	Yes	No
R.	HIV, AIDS or ARC?	Yes	No

7. **ARE YOU USING ANY OF THE FOLLOWING:**

A.	Antibiotics?	Yes	No
B.	Anticoagulants (Blood Thinners)?	Yes	No
C.	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
D.	High Blood Pressure Medications?	Yes	No
E.	Steroids (Cortisone, etc.)?	Yes	No
F.	Tranquilizers?	Yes	No
G.	Insulin or Oral Anti-Diabetic drugs?	Yes	No
H.	Digitalis, Inderal, Nitroglycerin or other heart drugs?	Yes	No
I.	Any regular prescription medicine, pills or drug?	Yes	No
	If Yes, please list: _____		
J.	Herbal or Holistic remedies, Vitamins or over the Counter medications?	Yes	No
	If Yes, please list:_____		

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

A.	Local Anesthesia (Novocain, etc.)?	Yes	No
B.	Penicillin or other antibiotics?	Yes	No
C.	Sedatives, Barbiturates?	Yes	No
D.	Aspirin or Ibuprofen?	Yes	No
E.	Codeine or other pain Killers?	Yes	No
F.	Latex or Rubber Products?	Yes	No
G.	Other allergies or reactions? Please list:		

_____

9.	Do you Smoke or Chew Tobacco?	Yes	No
	How much per day? _____		
10.	Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?	Yes	No

11. **FEMALE ONLY**

A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? Yes No

B. Are you nursing? Yes No

C. **If you are using Oral Contraceptives,** it is important to understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I certify that I have read and understand the above. I acknowledge that my questions if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I have made in completion of this form.

_____	_____	_____
Date	Signature of Person Completing Health History (Parent or Legal Guardian)	Doctors Initials

By signing above, I consent for an examination and any diagnostic procedures.

Medical Update: I have read my Health History dated and confirm that it adequately states past and present conditions.

_____	_____	_____
Date	Exceptions or Changes	Patient's Signature (Parent or legal Guardian)
		_____ Doctor's Initials
_____	_____	_____
Date	Exceptions or Changes	Patient's Signature (Parent or legal Guardian)
		_____ Doctor's Initials
_____	_____	_____
Date	Exceptions or Changes	Patient's Signature (Parent or legal Guardian)
		_____ Doctor's Initials