Charles H. Surles D.D.S.

ADULT EXAMINATION AND HEALTH INFORMATION

NAME _____ D.O.B. _____ Today's Date: _____

Name of your Physician _____

General Health Questions

Has your health changed in the past year? ___ If yes, explain _____

Do you smoke? _____ If yes, how much per day? _____ and for how long? _____

Do you use smokeless tobacco products? _____ If yes, how much? _____ and for how long? _____

Do you have a joint replacement or implant? _____

Have you had a heart valve replacement or vascular graft? _____

Have you ever taken anticoagulants (blood thinner)? _____ When and for how long? _____

Have you ever been diagnosed with cancer? _____ If so, area of body or type? _____

Chemotherapy or Radiation treatment? _____

Do you bruise easily? _____

Are you aware of any sores or growths in or around your mouth? _____

Do you snore/ or have sleep apnea? _____

Are you aware of grinding or clenching your teeth? _____

List any major surgeries that you have had in the past 5 years:

_____ _____

Please list any medications that you may be taking, prescription or non prescription, including aspirin, diet supplements or vitamins: (Please list medication, dosage and frequency)

_____ _____

_____ _____

Have you ever been pre-medicated for dental treatment? _____

Have you ever had, or do you have now, any of the following? ***(Check all that apply)***

◯ heart attack	◯ fainting spells	◯ Hepatitis A B C D	◯ ulcers
◯ stroke	◯ skin disease	◯ bowel disease	◯ arthritis
◯ mitral valve prolapse	◯ psychiatric treatment	◯ thyroid disease	◯ bleeding
◯ auto immune disease	◯ high blood pressure	◯ rheumatism	◯ glaucoma
◯ rheumatic fever	◯ kidney trouble	◯ clotting problems	◯ AIDS virus
◯ low blood pressure	◯ lung trouble	◯ herpes virus I or II	◯ asthma
◯ diabetes	◯ liver trouble	◯ chemical dependency	◯ epilepsy
◯ excessive thirst	◯ sinus trouble	◯ tuberculosis	◯ anemia

Medicines and Drug Allergies

Are you allergic to latex?_____

Note the drug(s) you have reacted adversely to or allergic to: ◯ Penicillin ◯ aspirin ◯ codeine

◯ Valium ◯ antihistamines ◯ amoxicillin ◯ local anesthetics ◯ Other _____

Are you taking, or have you ever taken, bone density medications? (Such as Fosamax, Boniva, Actonel, Zometa, Aredia or Reclast?) _____

Women

Are you pregnant? _____ Do you take oral contraceptives? _____

Have you reached menopause? _____ If yes, are you taking hormone or calcium supplements? _____

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 made to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of the form.

_____

Signature of Patient (or responsible party) *DATE*