

**DR. CHARLES STONE JR. D.D.S. & DR. BARRY ACKER D.D.S.**  
**ORAL & MAXILLOFACIAL SURGERY**

PLEASE PRINT

ALL RESPONSES ARE KEPT CONFIDENTIAL

Today's Date / /		Patient's Name		Sex	Age	Birthdate		Soc Sec #	
Address			City		State	Zip Code	Phone		Home Cell Work
Spouse's Name		Physician's Name		Referring Dentist's Name			Orthodontist's Name		
Reason for visit			Family Members who have been Patients here			Patient's Place of Employment			
Responsible Party's Name		Relationship to Patient		Billing Address			Phone		Home Cell Work
Insurance Holder's Name			Birthdate		Soc Sec #		Relationship to Patient		
Name of Insurance Plan			Group #		Employer (Company name and address)				

Please answer ALL questions by checking Yes or No

1. Are you in good health?	___ Yes	___ No	7. Are you using or taking any of the following:		
2. Has there been ANY changes in your general health?	___ Yes	___ No	a) Antibiotics or sulfa drugs?	___ Yes	___ No
3. Date of last physical exam?			b) Anticoagulants (blood thinners)?	___ Yes	___ No
4. Are you now under a physician's care for a particular problem? Please describe:	___ Yes	___ No	c) High blood pressure medicine?	___ Yes	___ No
			d) Steroids (cortisone, etc.)?	___ Yes	___ No
5. Have you had any serious illness, operations or hospitalizations? Please describe?	___ Yes	___ No	e) Tranquilizers (valium, etc.)?	___ Yes	___ No
			f) Insulin, diabenese, or similar drug?	___ Yes	___ No
6. Do you or have you ever had the following:	___ Yes	___ No	g) Digitalis, inderal, nitroglycerin, or other heart medicine?	___ Yes	___ No
			h) Vitamins/Herbal Supplements?	___ Yes	___ No
a) Rheumatic fever or rheumatic heart disease?	___ Yes	___ No	i) Aspirin? How much daily:	___ Yes	___ No
b) Congenital heart disease	___ Yes	___ No	j) Marijuana or other "street" drugs	___ Yes	___ No
c) Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker)?	___ Yes	___ No	k) WOMEN: Birth Control pills?	___ Yes	___ No
			l) Are you taking any other regular medications, pills or drugs? If so, please list:	___ Yes	___ No
d) Lung disease (asthma, emphysema, chronic cough, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	___ Yes	___ No	7. Are you currently taking or have you ever taken bisphosphonate drugs?	___ Yes	___ No
e) Neurologic-Psychological disorders (convulsions, epilepsy, seizures, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown)?	___ Yes	___ No	8. Are you allergic or had a bad reaction to:		
			a) Local anesthetic (novocain, etc.)?	___ Yes	___ No
f) Blood disease (anemia, bleeding tendency, blood transfusion, do you bruise easily)?	___ Yes	___ No	b) Penicillin or other antibiotics?	___ Yes	___ No
			c) Barbituates, sedatives, etc.?	___ Yes	___ No
g) Liver disease?	___ Yes	___ No	d) Aspirin?	___ Yes	___ No
h) Kidney disease?	___ Yes	___ No	e) Codeine or other painkillers?	___ Yes	___ No
i) Diabetes?	___ Yes	___ No	f) Other allergies or reactions? Please Describe:	___ Yes	___ No
j) Thyroid disease (goiter)?	___ Yes	___ No			
k) Arthritis?	___ Yes	___ No			
l) Stomach ulcers or colitis?	___ Yes	___ No			
m) Glaucoma?	___ Yes	___ No			
n) Frequent or recurring mouth sores?	___ Yes	___ No	9. Have you ever sought professional care for drug abuse, alcoholism or emotional disorders?	___ Yes	___ No
o) Implants placed anywhere in your body? (heart valve, hip, knee) Please describe:	___ Yes	___ No	10. WOMEN: Are you pregnant or planning pregnancy?	___ Yes	___ No
			11. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?	___ Yes	___ No
p) Radiation or Chemotherapy treatment for cancer? Please describe:	___ Yes	___ No	12. Do you wish to talk to the doctor privately about anything?	___ Yes	___ No
q) Clicking or popping of the jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?	___ Yes	___ No	I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor.		
r) Sinus or nasal problems?	___ Yes	___ No	SIGNATURE of person completing health history _____ Dr's Initials _____		
s) Any disease, drugs or transplant operation that has depressed your immune system? Please describe:	___ Yes	___ No			
t) Recurrent infections of any kind?	___ Yes	___ No			

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	Dr' Initials
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