Cosmetic,
Full Mouth Reconstruction,
TMJ & Sleep Apnea Dentistry

IRA D. KOEPPEL DDS

"Changing Lives... One Smile at a Time"

ADULT HEALTH HISTORY

Patient Name:_____

GENERAL HEALTH: excellent ❑ good ❑ fair ❑ poor ❑
Any change in general health in past 5 years? _____
Have you ever been hospitalized? _____

Name of Physician:_____ Phone_____
Date of last medical exam and reason _____
Are you presently under medical care? _____ for what? _____
Are you presently taking any medication, including aspirin, vitamins, b, c, pills?_____
If yes, for what: _____

Are there any medications that make you sick or ill? _____
Are you sensitive or allergic to: Penicillin Yes ❑ No ❑ Codeine Yes ❑ No Novocaine ❑ Yes ❑ No Aspirin ❑ Yes ❑ No ❑
Other: _____

Do you smoke cigarettes, pipe or chew tobacco? _____
Have you ever taken bisphosphinates? (Ex. Fosamax, Zometra, Aredia, Boniva, Actonel. This is not a complete list; other bisphosphiates may not be listed here) _____
If so for how long? And if stopped, when? _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

_____Abnormal Bleeding
_____AIDS
_____Anemia
_____Angina
_____Anxiety
_____Aortic Bypass
_____Arrhythmia
_____Artificial Heart Valve
_____Artificial Joint/Limb
_____Asthma
_____ Back Problems
_____Blood Thinners
_____Cancer
_____Chemotherapy
_____Diabetes
_____Drug Dependency
_____Emphysema
_____Epilepsy
_____Epinephrine Sensitivity
_____Excessive Bleeding
_____Fainting Tendency
_____Glaucoma
_____Hearing Deficiency
_____Heart Attack
_____Heart Disease
_____Heart Murmur
_____Hepatitis A (infectious)
_____Hepatitis B (serum)
_____Hepatitis C
_____Hi/Low Blood Pressure
_____HIV
_____Jaundice
_____Kidney Disease
_____Liver Disease
_____Mitral Valve Prolapse
_____Pacemaker
_____Prolapsed Valve
_____Radiation Therapy
_____Recovering Alcoholic
_____Respiratory Problems
_____Rheumatic Fever
_____Sinus Problems
_____Sleep Apnea
_____Smoker
_____Stomach Problems
_____Stroke
_____Thyroid Disease
_____Tuberculosis
_____Tumors
_____Ulcers
_____ Venereal Disease

WOMEN: Are you pregnant now or think you are pregnant? Yes ❑ No ❑
FAMILY HISTORY: ❑ Diabetes ❑ Hi B. P. ❑ Heart Problems ❑ Epilepsy ❑ Cancer
Do you have any disease, condition or problem not listed above that you think I should know about?
_____
_____

I verify the above and give consent for dental treatment: _____ Date: _____