contact@azdentalsurgery.com | www.azdentalsurgery.com

Medical History Form

Patient Name: ______________________________Date: ____________ Sex: M / F

Date of Birth: _______________ Age: ____ Height: ___________ Weight: ______lbs.

Phone: (______) ______________________

Below info is for us to electronically send prescriptions so they will be ready to pick up on the way home after surgery.

Patient's Address: ____________________________________ City: __________ Patients Zip Code: ________

Preferred Pharmacy Name: __________________

Pharmacy Address: ____ Pharmacy Zip Code: _________

If you are completing this form for someone else, what is your relationship to the patient? __________________

1. Are you taking any prescription or non-prescription medications.................................Yes No

If so, please list and explain below

Medication	Reason for using medication	Medication	Reason for using medication
1)..		5)	
2)		6)	
3)		7)	
4)		8)	

2. My last physical exam was on ____
3. Are you presently under the care of a physician ....Yes No
   If so, for what condition ____
4. Have you ever been hospitalized or had a serious illness or operation ....Yes No
   If so, please explain ____
5. Allergic reaction to any drug, food, or substance ....Yes No
   If so, please explain cause: ____________________*& reaction:* ______________________
6. Family history of anesthetic or anesthesia complications....................................Yes No
   If so, please explain: ____
7. Have you had abnormal bleeding ....Yes No
8. Do you have any blood disorder such as anemia, hemophilia, sickle cell anemia, HIV ....Yes No
9. Have you ever had treatment for a tumor or cancer..Yes No
10. Have you ever had radiation therapy to the head, neck, or jaws ....Yes No
11. Are you taking or have you ever taken Bisphosphonates medications for osteoporosis or chemotherapy such as Fosamax, Actonel, Boniva, Aredia, or Zometa ....Yes No
12. Do you have or have you had any of the following diseases, problems, or conditions
    a. Artificial joint replacement (knee, hip, shoulder, etc.)..........................Yes No
    b. Congenital heart defect..Yes No
    c. Infective endocarditis ....Yes No
    d. Damaged heart valves or artificial valves..Yes No
    e. Cardiovascular disease, heart trouble, heart attack, or any other heart condition ....Yes No
    f. Irregular heart beat or heart murmur ....Yes No
    g. Stroke..Yes No

h. Ever required a blood transfusion .... Yes No
i. Issues with your spleen .... Yes No
j. High blood pressure .... Yes No
k. Low blood pressure or fainting .... Yes No
l. Asthma .... Yes No
   i. If so, have you ever been hospitalized or gone to ER for asthma?_______________
m. Respiratory problems, emphysema, bronchitis, tuberculosis, etc. .... Yes No
n. Persistent cough that produces blood .... Yes No
o. Sinus trouble .... Yes No
p. Sleep apnea .... Yes No
q. Do you snore .... Yes No
r. Seizures, epilepsy, or neurological disorder .... Yes No
s. Alzheimer's or Dementia .... Yes No
t. Diabetes .... Yes No
   i. If so, Type_______ last A1C #_________ Date of last A1C_____________
u. Hepatitis, jaundice, or liver disease .... Yes No
v. Kidney trouble .... Yes No
w. Thyroid problems .... Yes No
x. Arthritis or painful, swollen joints including jaw joint (TMJ) .... Yes No
y. Osteoporosis .... Yes No
z. Stomach ulcers or hyperactivity .... Yes No
aa. Glaucoma .... Yes No

13. Have you had any serious trouble associated with previous dental treatment .... Yes No
    If so, please explain: ____
14. Do you have any other condition or disease the doctor should know about .... Yes No
    If so, please explain: ____
15. Do you have a nervous/ psychiatric condition (including depression/ anxiety) .... Yes No
    If so, please explain: ____
16. Do you smoke, vape, or use chew tobacco .... Yes No
    If so, please specify frequency and type ________________________________
17. Do you drink alcoholic beverages .... Yes No
    If so, please specify frequency and amount ______________________________
18. History of drug or substance abuse .... Yes No
    If so, please specify ____

Females:

19. Are you pregnant or trying to become pregnant .... Yes No
20. Are you nursing .... Yes No
21. Are you taking oral contraceptives/ hormonal therapy .... Yes No
22. Do you have menstrual problems .... Yes No

I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. ALL QUESTIONS I HAD ABOUT THIS FORM HAVE BEEN ANSWERED. I UNDERSTAND IT IS MY RESPONSIBILITY TO FILL OUT THE FORM CORRECTLY AND COMPLETELY.

Additional comments you would like the doctor to know:

Patient's Signature (or Legal Guardian): ____________________________

Pre-Surgery Instructions

If you are having Intravenous (IV) Conscious Sedation

- You **cannot eat or drink anything for at least 6 hours** prior to your surgery
  - Although, patients can have **WATER ONLY up to two hour prior** to the appointment, but no other liquids or food for 6 hours prior.
  - Any prescription medications should be taken at their regular times with no more than a few small sips of water.
- A **responsible adult (legal guardian if under 18) must accompany you to the appointment and REMAIN in the office** throughout the surgery.
  - The accompanying adult must be able to drive you home and remain with you until you are alert (about 4-5 hours).
- **Wear loose non-restrictive clothing with short sleeves** so that we can start the IV in your arm.
- Wear **shoes that are securely fastened** (ex: no sandals).
- **Female patients**: must **be sure you are not pregnant** prior to any sedation. If you feel you may be pregnant, please notify the doctor prior to the appointment.
- Sedated patients will not be able to perform activities that require coordination for 24 hours such as driving or cooking.
- Intravenous conscious sedation is a safe reliable method of providing relief from the fears and apprehensions of surgery. Various drugs will be administered making you very relaxed, and sleepy. If you have questions pertaining to IV conscious sedation, please feel free to contact Dr. Woodmansee with the above contact information.

Steps to a Smooth Surgery Day

- Planning for your surgery will make your day go much smoother. **Purchasing ice packs and liquid diet foods before the surgery** will allow to you to rest and recover sooner. Liquid diet foods include items like yogurt, pudding, tomato soup, ensure shakes, and mashed potatoes.
- Anyone under the age of 18 must be accompanied by the legal guardian at the appointment time.
- Ensure you arrive for your appointment on-time and have planned for adequate recovery time.
  - Wisdom teeth usually require 3 days of recovery time.
- Smoking in the weeks prior to surgery greatly increases your chances of complications. If you smoke, it is best to refrain or limit as much as possible for at least 1 week prior to surgery.
- If you have any questions regarding your surgery after reading the following instructions, please do not hesitate to contact Dr. Woodmansee with the above contact information.

In voting done by over 150 Phoenix Dentists Dr. Woodmansee was named…