

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 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.
 - Most patients are in and out of the office in 1.5hrs. The accompanying adult must be able to drive you home and remain with you until you are alert (stay with you after the surgery for at least 2-3 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, liquid diet foods and Tylenol 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.

Scan the codes below with your cell phone's camera to view our instructional videos



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

