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): _____

BRENT WOODMANSEE D.M.D. PLLC
contact@azdentalsurgery.com | www.azdentalsurgery.com

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

PRE-OPERATIVE

POST-OPERATIVE

PRESCRIPTIONS

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

PHOENIX MAGAZINE 2019 TOP DENTISTS
PHOENIX MAGAZINE 2020 TOP DENTISTS
PHOENIX MAGAZINE 2021 TOP DENTISTS
PHOENIX MAGAZINE 2022 TOP DENTISTS
PHOENIX MAGAZINE 2023 TOP DENTISTS
PHOENIX MAGAZINE 2024 TOP DENTISTS
PHOENIX MAGAZINE 2025 TOP DENTISTS