DEAN C. YOUNCE, D.M.D., P.A.
Oral and Maxillofacial Surgery

NAME:_____ DATE:_____

Please answer all questions by circling (Y) Yes or (N) No

1. ARE YOU IN GOOD HEALTH?…… Y N
2. HAS THERE BEEN ANY CHANGE IN YOUR HEALTH IN THE LAST YEAR?…… Y N
3. DATE OF YOUR LAST PHYSICAL EXAM? _____
4. NAME OF PHYSICIAN: _____
   NAME OF DENTIST: _____
5. ARE YOU NOW UNDER A PHYSICIAN'S CARE FOR A PARTICULAR PROBLEM?….. Y N
6. WHAT IS YOUR? HEIGHT: _____, WEIGHT: _____, AGE: _____
7. HAVE YOU HAD ANY ILLNESSES, OPERATIONS OR HOSPITALIZATIONS?……... Y N
   IF SO, PLEASE DESCRIBE: _____
   (Please give dates) _____
8. DO YOU HAVE OR HAVE YOU EVER HAD:

   A. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE?…… Y N
   B. CONGENITAL HEART DISEASE?…… Y N
   C. CARDIOVASCULAR DISEASE (Heart Trouble, Heart Attack, Heart Murmur, Coronary Artery Disease, High Blood Pressure, Angina, Stroke, Palpitations, Heart Surgery, Pacemaker)?……. Y N
   D. LUNG DISEASE (Asthma, Emphysema, Chronic Cough, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Cough)?……. Y N
   E. NEUROLOGIC-PSYCHOLOGICAL DISORDERS (Convulsions, Epilepsy, Seizures, Fainting, Psychiatric Treatment, Dizziness, Nervous Disorder or Breakdown)?…… Y N
   F. BLOOD DISEASE (Anemia, Blood Transfusion, Bleeding Tendency, or Bruise Easily)?……... Y N
   G. LIVER DISEASE (Jaundice, Hepatitis)?……... Y N
   H. KIDNEY DISEASE?…… Y N
   I. DIABETES?…… Y N
   J. THYROID DISEASE (Goiter)?…… Y N
   K. ARTHRITIS?…… Y N
   L. STOMACH ULCERS OR COLITIS?……... Y N
   M. GLAUCOMA?……... Y N
   N. FREQUENT OR RECURRING MOUTH SORES?……. Y N
   O. IMPLANTS OR PROSTHESIS (Heart Valve, Hip, Knee, Etc.)…… Y N
   P. RADIATION (X-RAY) TREATMENT FOR CANCER?…… Y N
   Q. CLICKING OR POPPING OF JAW JOINT, PAIN NEAR EAR, DIFFICULTY OPENING MOUTH, GRIND OR CLENCH TEETH?……Y N
   R. SINUS OR NASAL PROBLEMS?……... Y N
   S. A DISEASE, DRUG, OR TRANSPLANT WHICH HAS DEPRESSED YOUR IMMUNE SYSTEM?…… Y N
   T. RECURRENT INFECTIONS OF ANY KIND?……... Y N

9. ARE YOU USING OR TAKING ANY OF THE FOLLOWING:

A. ANTIBIOTICS OR SULFA DRUGS?…….. Y N
B. ANTICOAGULANTS (Blood Thinners)?……..... Y N
C. HIGH BLOOD PRESSURE MEDICINE?…… Y N
D. STEROIDS (Cortisone, Etc.)?…….. Y N
E. TRANQUILIZERS (Valium, Etc.)?…… Y N
F. INSULIN, DIABENESE, OR SIMILAR DRUG?…… Y N
G. DIGITALIS, INDERAL, NITROGLYCERIN OR OTHER HEART MEDICINE?…… Y N
H. ASPIRIN? HOW MUCH DAILY? _____ …….. Y N
I. MARIJUANA OR OTHER "STREET" DRUGS?……...Y N
J. MEDICINES FOR LOW BONE DENSITY?……Y N
K. ARE YOU TAKING ANY OTHER MEDICATIONS, PILLS, OR DRUGS?…… Y N
IF YES, PLEASE LIST: _____
_____

10. ARE YOU ALLERGIC TO OR HAVE YOU HAD A BAD REACTION TO:

A. LOCAL ANESTHETICS (Novocaine, Lidocaine, Etc.)?……..……..……... Y N
B. PENICILLIN OR OTHER ANTIBIOTICS?…… Y N
C. BARBITURATES, SEDATIVES, ETC.?…… Y N
D. ASPIRIN?…….. Y N
E. CODEINE OR OTHER PAINKILLERS?…… Y N
F. OTHER ALLERGIES OR REACTIONS?……..……...Y N
IF YES, PLEASE LIST: _____

11. HAVE YOU EVER SOUGHT CARE FOR DRUG ABUSE, ALCOHOLISM OR EMOTIONAL DISORDERS?…… Y N

12. ARE YOU, OR HAVE YOU TAKEN ANY DIET MEDICINES?……. Y N

13. DO YOU HAVE ANY OTHER DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT?……...Y N

14. DO YOU SMOKE…….... Y N
IF YES, HOW MANY CIGARS, CIGARETTES, OR PIPES A DAY?_____

15. WOMEN: A. ARE YOU PREGNANT OR PLANNING PREGNANCY?…… Y N
B. ARE YOU BREAST-FEEDING?…….. Y N
C. ARE YOU TAKING BIRTH CONTROL PILLS?……... Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I ALSO GIVE DR. YOUNCE MY PERMISSION TO FORWARD THIS HEALTH HISTORY, ALONG WITH ANY OTHER PORTION OF MY RECORD, TO OTHER DENTISTS, PHYSICIANS, OR INSURANCE COMPANIES, AS NECESSARY.

_____ _____ _____
PATIENT'S SIGNATURE DATE DOCTOR'S INITIALS