NORTH VALLEY CENTER
FOR ORAL AND IMPLANT SURGERY
Caring, compassionate, and precise
DR. DONALD JOHNSON

Medical History Form

Dentist Name: _____ Physicians Name: _____
Referred By: _____ Physician's Telephone #: _____

Are you in good health? ----------	Y	N	Date of Last Doctor Visit: _____		
Heart Disease? Heart Attack? -----	Y	N	Chest Pain (Angina)----------	Y	N
Heart Pacemaker or surgery---------	Y	N	Anemia (Iron def. or sickle cell)----------	Y	N
Rheumatic fever/ Heart murmur----	Y	N	Shortness of breath or exertion----------	Y	N
Artificial Heart Valve----------	Y	N	Lung Disease (T.B. Emphysema, Bronchitis)	Y	N
Asthma----------	Y	N	Difficulty breathing lying down----------	Y	N
Swollen Ankles/Arthritis----------	Y	N	Sinus Disease or Hay Fever----------	Y	N
High/Low Blood Pressure----------	Y	N	Thyroid Disease----------	Y	N
Stroke----------	Y	N	Diabetes----------	Y	N
Ulcers----------	Y	N	Kidney Disease----------	Y	N
Glaucoma or Eye Disease----------	Y	N	Liver Disease (Cirrhosis, Jaundice)----------	Y	N
Use Cocaine or Methamphetamine-	Y	N	Epilepsy or Seizures----------	Y	N
Cortisone Medicine ----------	Y	N	Fainting or Dizzy Spells----------	Y	N
Pain or Clicking in Jaw Joint--------	Y	N	Psychiatric Treatment----------	Y	N

Have you ever taken bisphosphonates or treated for osteoporosis, Multiple Myeloma, Paget's disease or metastatic bone cancer?----------	Y	N
Have you had any illness or hospitalized during the past 5 years? ----------	Y	N
Have you ever had a problem with local or general anesthesia? ----------	Y	N
Have you ever had prolonged bleeding after minor cuts, tooth extraction, surgery, or nosebleeds? -----	Y	N
Do you use aspirin, blood thinning medications, or herbal preparations? ----------	Y	N
Are you allergic to local anesthetics or any other medication? ----------	Y	N
(Women) Are you or do you anticipate becoming pregnant in the next few months? Anesthetics may harm your baby. ----------	Y	N
If you are using oral contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives.		
Have you ever had any radiation treatment or chemotherapy for cancer? ----------	Y	N
Do you wear contact lenses? ----------	Y	N
Do you have any problems, disease or condition not listed on the form? ----------	Y	N
Are you or have you ever been addicted to drugs or alcohol? ----------	Y	N
Do you use any tobacco products or snuff? ----------	Y	N
Do you use weight control medication? ----------	Y	N
Do you wish to talk with the doctor privately about anything? ----------	Y	N

Please provide a list of your medications, or write them below:

_____

_____

Please provide a list of surgeries/sedations, or write them below:

_____

_____

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health history or change of medicine I will inform Dr. Johnson at my next appointment.

_____/_____/_____

Signature of Patient, Parent or Guardian Staff Date