ABILENE WISDOM TEETH
IV SEDATION - WISDOM TEETH - IMPLANTS

MEDICAL HISTORY

Patient's Name (print) _____ DOB _____ Height _____ Weight _____

1. Have you ever had any problems with: *(check all that apply)*

☐ **Heart**	☐ **Diabetes**	☐ **Lungs**
☐ **Epilepsy**	☐ **Kidney**	☐ **High Blood Pressure**
☐ **Liver**	☐ **Asthma**	☐ **Low Blood Pressure**
☐ **Seizures**	☐ **Allergies**	☐ **Snoring**
☐ **Sleep apnea**	☐ **Reaction to anesthetic** *(General, Local, Sedation)*	

Explain any checked boxes: _____

Staff Use Only

Pre-Op Vitals- BP: _____

Pulse: _____ SPO2: _____

2. Medications routinely used at home: _____

3. What medications, if any, are you allergic to? _____

4. Past surgeries:

Dates **Operation** **Type of Anesthesia** *(General, local, sedation)*

_____

_____

_____

5. Do you smoke? _____

Packs / Day? _____ Number of years? _____

6. Do you drink alcohol? _____

How often? _____ Drugs? _____

7. Have you ever taken Bisphosphonates (i.e. Boniva, Fosamax)? _____

8. Have you ever had any other health problems we should know about? _____

9. Is there any chance that you may be pregnant? _____

_____ _____

Patient's or Guardian's Signature Date

_____ _____

Witness Signature Date

_____ _____

Doctor's Signature Date