LONE STAR DENTAL ANESTHESIA
4112 East Renner Road
Richardson, TX 75082
info@lonestarda.com

1. ADULT HEALTH HISTORY FORM (CONFIDENTIAL)

2. **Please enter your information here.**

Last Name: _____ First Name: _____ Date: _____

Address: _____ Apt/Unit #: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Gender:
○ Male ○ Female

Height: _____

Weight in lbs: _____

Emergency Contact: _____ Phone Number: _____

If you are completing this form for another person, what is your relationship to that person? _____

3. **Please answer the following questions. Your answers are for our records only and will be considered confidential.**

Please describe your current physical health?
○ Excellent ○ Good ○ Poor

Has there been any change in your general health within the past year?
○ Yes ○ No

My last complete physical exam was on _____

Are you now under the care of a physician?
○ Yes ○ No

Date of last cold, cough, or fever: _____

Do you experience shortness of breath?
○ At rest ○ Minimal exertion
○ Moderate exertion

4. **If you are currently under the care of a physician:**

What is the condition being treated? _____

Physician's Name: _____ Phone Number: _____

5. **Have you had any illness or operation that required hospitalization?**

○ Yes
○ No

6. Please list any illnesses or operations:

7. Please describe your routine physical activity

8. Do you have or have you had any of the following diseases or problems?

- ☐ Damaged heart valves
- ☐ Artificial heart valves
- ☐ Knee replacement
- ☐ Hip replacement
- ☐ Plastic or artificial arteries
- ☐ Congenital heart defect(s)
- ☐ Heart murmur
- ☐ Cardiovascular disease
- ☐ Heart trouble
- ☐ Heart attack
- ☐ Coronary insufficiency
- ☐ Coronary occlusion
- ☐ High blood pressure (hypertension)
- ☐ Atherosclerosis
- ☐ Stroke

9. Do you have chest pain upon exertion?
○ Yes ○ No

Do your ankles swell?
○ Yes ○ No

Do you get short of breath when you lie down, or do you require extra pillows when you sleep?
○ Yes ○ No

Do you have a cardiac pacemaker/defibrillator?
○ Yes ○ No

Do you have an arrhythmia or an irregular heart beat?
- ☐ Arrhythmia
- ☐ Irregular heart beat

Have you ever been diagnosed with sleep apnea?
○ Yes ○ No

Have you ever had:
- ☐ Kawasaki's disease
- ☐ Rheumatic fever
- ☐ Scarlet fever

Have you ever had:
- ☐ Asthma ☐ Bronchitis
- ☐ Emphysema
- ☐ Persistent cough
- ☐ Tuberculosis ☐ Wheezing
- ☐ Hay fever

Have you ever had:
- ☐ Fainting Spells ☐ Seizures
- ☐ Epilepsy

Please explain the cause of any fainting spells, seizures or epilepsy:

Have you ever had:
- ☐ Diabetes
- ☐ Thyroid gland condition
- ☐ Pituitary gland condition
- ☐ Adrenal gland condition

Have you ever had:
- ☐ Hepatitis ☐ Jaundice
- ☐ Liver disease

Have you ever been told not to donate blood?
○ Yes ○ No

If yes, why?

AIDS or tested positive for HIV?
○ Yes ○ No

Arthritis or inflammatory rheumatism?
○ Yes ○ No

Stomach ulcers?
○ Yes ○ No

Kidney trouble?
○ Yes ○ No

Low blood pressure?
○ Yes ○ No

Have you ever had a nervous breakdown or psychotherapy?
○ Yes ○ No

Do you have a history of alcoholism or drug dependence?
○ Yes ○ No

Have you ever taken any "recreational" drugs in the past such as cocaine, crack, marijuana, LSD?
○ Yes ○ No

10. **If you have ever taken any "recreational" drugs in the past, please explain what and when:**

_____

_____

_____

_____

11. Do you have a history of smoking?
○ Yes ○ No

If yes, how many per day and for how many years?

_____

Do you have a history of drinking alcohol?
○ Yes ○ No

If yes, how much do you drink per day averaged over the week?

_____

Do you bleed or buise easily?
○ Yes ○ No

Do you have:
☐ Hemophilia
☐ Von Willebrand Disease

Do you have any blood disorder, such as anemia or sickle cell anemia?
○ Yes ○ No

Have you ever received a blood transfusion?
○ Yes ○ No

Have you ever had:
☐ Surgery ☐ X-ray treatment

Have you ever had chemotherapy for:
☐ Tumor ☐ Cancer ☐ Other

12. **Please list all medications you are currently taking:**

_____

_____

_____

_____

13. **Please list all allergies to medication, latex, or food:**

_____

_____

_____

_____

14. Have you or a close relative ever had a bad reaction to any anesthetic drug?
○ Yes ○ No

Have you ever had complications during a previous anesthetic?
○ Yes ○ No

Do you have any disease, condition, or problem not mentioned above?
○ Yes ○ No

Please list any disease, condition, or problem not mentioned above:

_____

15. **Women only:**

Is there any possibility that you are pregnant?
○ Yes ○ No

Are you a nursing mother?
○ Yes ○ No

The information on this questionnaire is accurate to the best of my knowledge and that withholding any information could result in injury or death. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform the anesthesiologist of any changes in my medical status at the earliest possible time.

Signature of Patient

_____ _____
Signature Date

Reviewed by: Jinsoo Kim, DDS/William Baltazar, DDS/Hunter Stuart, DDS

_____ _____
Signature Date

_____ _____
Signature Date