Print

ACADIAN ORAL SURGERY

ROBERT L. LEVY, DDS ,LLC

Date:

Name: Last: First: Middle

Address: City: State: Zip:

Date of Birth: / / Age: Sex:

Marital Status: Single Married Divorced Widowed

Home Phone: ( ) - Business Phone: ( ) -

Social Security Number: - -

Place of Employment:

Who referred you to our office?

Who is financially responsible for your account?

Daytime Phone Number: ( ) -

HEALTH HISTORY

PLEASE ANSWER EACH QUESTION

Are you under a physician's care at this time? Yes No

Nature of Illness or Illnesses?

Last Physical examination?

Physician's Name:

Have you had any serious illness or operations? Yes No

Please explain :

Are you currently taking any blood thinners? Yes No Type:

TO COMPLETE THE REST OF THIS FORM, PLEASE TURN OVER TO BACK PAGE.

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO.

Rhuematic Fever or Rhuematic Heart Disease Yes ☐ No ☐

Artificial joints Yes ☐ No ☐

Do you have: Pins, Plates, or Screws Yes ☐ No ☐

Mitral Valve Prolapse Yes ☐ No ☐

Heart Murmur Yes ☐ No ☐

Fainting Spells Yes ☐ No ☐

Diabetes Yes ☐ No ☐

Arthritis Yes ☐ No ☐

Hepatitis or Liver Disease Yes ☐ No ☐

High or Low Thyroid Yes ☐ No ☐

Sinus, Asthma or Hay Fever Yes ☐ No ☐

Heart Trouble Yes ☐ No ☐

High Blood Pressure Yes ☐ No ☐

Congenital Heart Lesions Yes ☐ No ☐

Heart Disease Yes ☐ No ☐

Chest Pain Yes ☐ No ☐

Shortness of Breath Yes ☐ No ☐

Do your ankles swell Yes ☐ No ☐

Glaucoma Yes ☐ No ☐

HIV or Aids Yes ☐ No ☐

History of Drug Abuse Yes ☐ No ☐

Emotional or Psychiatric Problems Yes ☐ No ☐

Please list and explain in detail any disease, condition, or problem not listed above:

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING:

If you have a list that can be copied, please give it to the receptionist.

Medication/Dosage:

ARE YOU ALLERGIC TO ANY MEDICATION? YES ☐ NO ☐ If yes please list below:

ARE YOU PREGNANT? YES ☐ NO ☐

ARE YOU BREASTFEEDING? YES ☐ NO ☐

Signature of Patient: _____ **Date:**

Signature of Parent or Guardian : _____ **Date:**