Chino Valley Oral Surgery

12860 10th St Ste A, Chino, CA 91710
(909) 591-0241 · Fax (909) 591-1691

INFORMATION REQUIRED FOR CASE HISTORY RECORD

This complete confidential record is important for our records and your health

Have you ever been a patient in this office before? ☐ **YES** ☐ **NO** Approximate date _____

Patient _____ Nickname _____ Date _____

Residence Address _____

Phone _____ City _____ Zip Code _____

CIRCLE ONE: MISS MRS. MS. MR. DR. REV.

SINGLE MARRIED SEPARATED DIVORCED WIDOWED

Email _____ Preferred Pharmacy _____

Date of Birth _____ Age _____ Social Security # _____ Driver's Lic # _____

Occupation _____ Employer _____

Business Address _____ City _____ Phone _____

Phone number where you can be reached during the day _____

IF PATIENT IS MARRIED COMPLETE THIS PORTION

Spouse's Name _____ Spouse's Occupation _____ Soc Sec # _____

Spouse's Employer _____ Phone _____

Address _____ City _____

IF PATIENT IS A SINGLE MINOR (UNDER 21 YEARS) COMPLETE THIS PORTION

Parent or Guardian's Name _____ Driver's Lic # _____

Person Financially Responsible _____ Soc Sec # _____

Occupation _____ Employer _____

Address _____ City _____ Phone _____

Name of nearest person not living with you _____ Relationship _____

Address _____ Phone _____

ALL PATIENTS

Physician _____ M.D. City _____ Phone _____

Dentist _____ D.D.S. City _____ Phone _____

Orthodontist _____ D.D.S. City _____ Phone _____

PLEASE PRINT THE NAME OF PERSON OR DOCTOR WHO REFERRED YOU TO THIS OFFICE

Name _____ Address _____

INSURANCE INFORMATION:

MEDICAL	PRIMARY DENTAL INS	SECONDARY DENTAL
Name	Name	Name
Address	Address	Address
Name of Policy Holder	Name of Policy Holder	Name of Policy Holder
Birthdate of Policy Holder	Birthdate of Policy Holder	Birthdate of Policy Holder
S.S. of Policy Holder	S.S. of Policy Holder	S.S. of Policy Holder

PLEASE TURN AND COMPLETE HEALTH HISTORY RECORD ON REVERSE SIDE

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HEALTH HISTORY

Please answer each question by checking the "YES" or "NO" column

☐ **YES** ☐ **NO** **1.** Are you now in good health?

a. If not, what medical conditions do you have? _____

2. My last physical examination was on _____

3. What operations have you had? _____

4. Do you now or have you ever had any serious illness or conditions such as: (please circle)

YES	NO		YES	NO	
☐	☐	Hepatitis	☐	☐	High blood pressure
☐	☐	Rheumatic fever	☐	☐	Stroke
☐	☐	Heart murmur	☐	☐	Diabetes
☐	☐	Kidney disease	☐	☐	HIV positive
☐	☐	Epilepsy	☐	☐	Thyroid condition
☐	☐	Heart disease	☐	☐	Lung disease, asthma

5. Please give details on any yes answers above: _____

6. Please list those medicines or drugs you take regularly or use: _____

7. Please list those medicines or materials you are allergic to (i.e. Penicillin, Tetracycline, Aspirin, latex): _____

☐ **YES** ☐ **NO** **8.** Have you ever received radiation or chemotherapy treatment for a tumor or growth of the head or neck?

☐ **YES** ☐ **NO** **9.** Do you have any infectious diseases (HIV, Hepatitis, etc.) or condition? If yes, explain _____

☐ **YES** ☐ **NO** **10.** Do you now have or have you ever had any heart trouble? (heart attack, heart failure, coronary insufficiency, coronary occlusion, etc.)

☐ **YES** ☐ **NO** **11.** Do you have chest pain on exertion (angina)?

☐ **YES** ☐ **NO** **12.** Are you short of breath on mild exertion?

☐ **YES** ☐ **NO** **13.** Do your ankles ever swell?

☐ **YES** ☐ **NO** **14.** Do you have a bleeding disorder?

☐ **YES** ☐ **NO** **15.** Has a doctor ever said you had liver disease, jaundice or hepatitis?

☐ **YES** ☐ **NO** **16.** Have you ever had psychiatric treatment?

☐ **YES** ☐ **NO** **17.** Do you smoke? If "YES" how many packs per day? ____ For how long? ____ Yrs.

☐ **YES** ☐ **NO** **18.** Do you now have a cold, cough or chest congestion?

☐ **YES** ☐ **NO** **19.** Do you regularly have a cough?

☐ **YES** ☐ **NO** **20.** Do you have lung disease (TB, emphysema)?

☐ **YES** ☐ **NO** **21.** Have you ever taken the drug Phen-Fen, Redux or other diet drugs?

☐ **YES** ☐ **NO** **22.** Do you have any disease, condition or problem not listed above that you think we should know about?

_____

☐ **YES** ☐ **NO** **23.** Do you wear contact lenses?

☐ **YES** ☐ **NO** **24.** Do you use alcohol, cocaine or marijuana regularly?

☐ **YES** ☐ **NO** **25.** Women: Are you pregnant at the present time?

I CONFIRM AS TRUE THE ABOVE HEALTH HISTORY INFORMATION. I UNDERSTAND THAT AN ACCURATE HISTORY IS ESPECIALLY IMPORTANT IF ANESTHESIA IS CONTEMPLATED.

Signature _____ Date _____

Doctor Signature _____ Date _____