PATIENT HEALTH HISTORY

Describe the reason for this visit: _____

When were you last examined by a medical doctor and for what? _____

List all medications you are currently taking (including non-prescription, homeopathic or "natural" remedies): _____

_____

List any allergies to drugs/medications: _____

What operations/surgeries have you had since birth? _____

Please describe any other medical problems or condition which may affect your treatment in this office? _____

_____

Height: _____ Weight _____

	Yes	No
Do you wear contact lenses?	_____	_____
Do you drink alcohol? If yes, how much?	_____	_____
Do you smoke cigarettes? If yes, how much?	_____	_____
Do you use recreational/street drugs?	_____	_____
Have you ever had local anesthesia (novacaine)	_____	_____
Have you ever been put to sleep for an operation?	_____	_____
Have you or anyone in your family ever had a problem with anesthesia? If so, specify_____	_____	_____
Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, Reclast, Boniva, Aredia or Zometa) for osteoporosis, chemotherapy, multiple myeloma, or Cancer? Intravenous (IV) or pill form	_____	_____

PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR CURRENTLY HAVE

- ☐ High Blood Pressure
- ☐ Circulatory Problems (stroke)
- ☐ Shortness of Breath
- ☐ Asthma or Lung Disease
- ☐ Respiratory problems, emphysema
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Cancer
- ☐ Tumor or growth
- ☐ Radiation or Chemotherapy
- ☐ Liver Disease/Jaundice
- ☐ Hepatitis or Mononucleosis
- ☐ Positive Test for HIV or Aids Virus
- ☐ Viral Infection such as Herpes
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Blood transfusions
- ☐ Psychiatric/Mental Disorders
- ☐ Candidiasis (Fungal Infection)
- ☐ Seizure Disorder (epilepsy)
- ☐ TMJ/Jaw Problems
- ☐ Arthritis
- ☐ Thyroid or Glandular Disease
- ☐ Glaucoma
- ☐ *Heart Murmur
- ☐ *Artificial/Prosthetic Heart Valve
- ☐ *Heart Disease/Chest Pain
- ☐ *Vascular Grafts
- ☐ *Mitral Valve Prolapse
- ☐ *Bone or Joint Replacements
- ☐ **None of the above**

***If you answered yes to any of these questions, have you been told by your physician that you should have antibiotics prior to dental treatment?** ☐ **Yes** ☐ **No**

FOR WOMEN ONLY

Are you pregnant or trying to become pregnant?	☐ Yes	☐ No
Are you breastfeeding?	☐ Yes	☐ No
Are you taking the birth control pill?	☐ Yes	☐ No
Do you understand that antibiotics, which might be prescribed for you, may interfere with the function of the birth control pill?	☐ Yes	☐ No

Is there anything you would like to discuss in private with your oral surgeon? ☐ Yes ☐ No

I hereby authorize release of my dental/medical information to Dr. Malik and release of my dental/medical information from Dr. Malik to my dentist or medical doctor as necessary.

_____ _____ _____ _____

Signature of Patient or Legal Guardian | Date | Signature of Doctor | Date

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

_____ _____ _____ _____

Date | Exceptions or changes | Patient signature | Doctor's initials

GRANITE STATE ORAL SURGERY

GRANITE STATE ORAL SURGERY

Opioid Risk Tool Assessment Instrument[1]

PATIENT: **DOB:**

Pursuant to State of New Hampshire Office of Legislative Services Administrative Rules (Chapter Med 500 Ethical Standards; Part Med 502 Opioid Prescribing; Section Med 502.4 Acute Pain), please complete this risk assessment in order for your doctor to be able to prescribe opioid medication (e.g. codeine, hydrocodone, Vicodin, Percocet) to assist with your post-operative pain control.

Patient's Risk Factors CHECK YES or NO [✕]		Y	N	Doctors use only F/M
Family History of Substance Abuse	Alcohol Abuse	[ ]	[ ]	1/3
	Illegal Drug Abuse	[ ]	[ ]	2/3
	Prescription Drug Abuse	[ ]	[ ]	4/4
Personal History of Substance Abuse	Alcohol Abuse	[ ]	[ ]	3/3
	Illegal Drug Abuse	[ ]	[ ]	4/4
	Prescription Drug Abuse	[ ]	[ ]	5/5
Personal Psychiatric History	Attention Deficit Disorder, Bipolar, Schizophrenia, or Obsessive Compulsive Disorder	[ ]	[ ]	2/2
	Depression	[ ]	[ ]	1/1
Personal History of Preadolescent Sexual Abuse		[ ]	[ ]	3/1
Patient's Age between 16 and 45		[ ]	[ ]	1/1
Doctor's use (total score) 3 or less = Low Risk 4 to 7 = Moderate Risk 8 or higher = High risk				

_____ _____

Patient (or Legal guardian's) signature Date

[1]Source: *Opioid Risk Tool Assessment Instrument* by Lynn Webster, MD

Doctor's initials: _____

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