

Marjon B. Jahromi, DDS

General Anesthesia and Sedation for Dentistry

HEALTH HISTORY

Today's Date: _____

PATIENT INFORMATION (CONFIDENTIAL)

Name:	Birth Date:	Age:
Address:	City:	
	State:	Zip:
Home Phone:	Social Security #:	

RESPONSIBLE PARTY

Name of Person Responsible for the Account:			
Relationship to Patient:		Driver's License #:	
Birth Date:	Home Phone:	Cell Phone / Pager:	
Address:	City:		
	State:		Zip:
Employer:		Social Security #:	

MEDICAL HISTORY

Have you ever had any of the following medical problems?	Yes	No		Yes	No
Allergies to any drugs	☐	☐	Sleep Apnea	☐	☐
Any Hospital Stays	☐	☐	Diabetes	☐	☐
Any Operations	☐	☐	Seizures / Epilepsy	☐	☐
Heart Defects	☐	☐	Handicaps / Disabilities	☐	☐
Asthma / Lung Problems	☐	☐	Cerebral Palsy	☐	☐
Hepatitis / Liver problems	☐	☐	Developmentally Delayed	☐	☐
Kidney Problems	☐	☐	Rheumatic / Scarlet Fever	☐	☐
Bleeding Problems	☐	☐	Cancer	☐	☐
Heart Murmurs	☐	☐	Hearing Impairments	☐	☐
WOMEN: Is there any possibility that you could be pregnant?	☐	☐	Tuberculosis	☐	☐

MEDICAL HISTORY

Please discuss any medical problems that you have / had:

Physician:

Phone Number:

Are you currently under the care of a physician:

Yes ☐ No ☐

Date of Last Visit:

Please describe your current physical health:

Excellent ☐ Good ☐ Poor ☐

Please list all medications you are currently taking:

Please list all allergies you have, including medications:

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform Dr. Marjon Jahromi of any changes in my medical status at the earliest possible time.

Signature

Date mm/dd/yy

Reviewed by

Date mm/dd/yy