Frederick G. Hegedus, D.D.S.
Oral & Maxillofacial Surgeon
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NewYork, NY 10019
1 (212) 759-2993

Health History

Health History reviewed by: (Doctor)	(Date)	(Doctor)	(Date)

Name:

Address:

City:	State:	Zip:

Sex:	Age:	Date of Birth:	Soc. Sec. #:

Phone (Home):	Phone (Work):
Occupation:	Dental Medical Insurance:

Employer:	Address:	
Physician:	Address:	Phone:
Dentist (Previous):	Address:	Phone:
Person to Notify in Case of Emergency:		Phone:
Referred by:	Address:	

Answer all questions. Check "Yes" or "No" as the question applies to you.

1. Have you ever had any serious illness, operations? Past hospital admissions? ☐ YES ☐ NO
   Please list: 1. _____
   2. _____
   3. _____
2. Are you in good health now? ☐ YES ☐ NO
3. My last physical exam was on
4. Are you under a physician's care at present? ☐ YES ☐ NO
   Is yes, for what problems?
5. Are you taking any medications or drugs? ☐ YES ☐ NO
   If yes, please list: 1. _____ 4. _____
   2. _____ 5. _____
   3. _____ 6. _____
6. Have you any history of drug abuse? ☐ YES ☐ NO
7. Are you allergic to any food or medicine?
   1. Penicillin ..... ☐ YES ☐ NO
   2. Local anesthetics..... ☐ YES ☐ NO
   3. Iodine..... ☐ YES ☐ NO
   4. Aspirin..... ☐ YES ☐ NO
   5. Other..... ☐ YES ☐ NO
   Please specify:
8. Do you have or had any of the following?

Anemia	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO
Kidney Disease.....	☐ YES ☐ NO	Thyroid Disease.....	☐ YES ☐ NO
Liver Disease.....	☐ YES ☐ NO	Lung (TB) Disease.....	☐ YES ☐ NO
Hepatitis.....	☐ YES ☐ NO	Arthritis	☐ YES ☐ NO
Epilepsy.....	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO
Nervous Diseases	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO
Stomach Ulcers	☐ YES ☐ NO	Heart Disease.....	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Hay Fever.....	☐ YES ☐ NO
Cancer or Tumor.....	☐ YES ☐ NO	Other _____	
AIDS/HIV	☐ YES ☐ NO		

Patient's Name *(please print)*	**Date**	
9. Do you get hives?	☐ YES	☐ NO
10. Do you have sinus problems?	☐ YES	☐ NO
11. Do your ankles swell?	☐ YES	☐ NO
12. Have you ever had Rheumatic Fever?	☐ YES	☐ NO
13. Do you have a heart murmur?	☐ YES	☐ NO
14. Do you have high blood pressure?	☐ YES	☐ NO
15. Have you had radiation treatment for a tumor, growth, or other condition?	☐ YES	☐ NO
16. Do you have to sleep with more than one pillow?	☐ YES	☐ NO
17. Do you urinate more than 6 times a day?	☐ YES	☐ NO
18. Have you had a recent gain or loss or weight?	☐ YES	☐ NO
19. Are you thirsty much of the time?	☐ YES	☐ NO
20. Do you bruise easily?	☐ YES	☐ NO
21. Do you bleed for a long time after scratching, cutting yourself or	☐ YES	☐ NO
after a dental extraction?		
22. Does anyone in your family have a bleeding problem?	☐ YES	☐ NO
If yes, who?		
23. Do you get sick after an injection?	☐ YES	☐ NO
24. Do you smoke?	☐ YES	☐ NO
25. Do you drink alcohol?	☐ YES	☐ NO
26. Did you have anything to eat or drink today?	☐ YES	☐ NO

For Women

27. Are you pregnant?	☐ YES	☐ NO
28. Do you have menstrual problems?	☐ YES	☐ NO
29. Are you taking birth control pills?	☐ YES	☐ NO
30. Have you reached menopause?	☐ YES	☐ NO

Dental

1. Are you aware of any particular dental problem?	☐ YES	☐ NO
2. Have you had any serious trouble associated with any dental procedures?	☐ YES	☐ NO
3. Do you wear partial or complete dentures?	☐ YES	☐ NO
4. Do you have any sores inside your mouth?	☐ YES	☐ NO
5. Do you get pains in the face and head other than toothaches?	☐ YES	☐ NO

What treatment do you desire?

I hereby consent to examination and diagnostic tests to enable the Oral Surgery to perform the necessary treatment for myself and / or my dependent to reestablish and maintain optimum oral health. I also give consent for necessary anesthetic agents.

X _____

Signature Date

X _____

Oral and Maxillofacial Surgery Representative Date