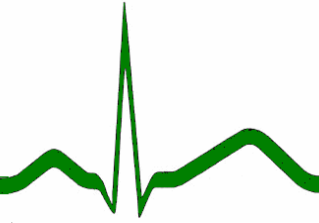


MCCARTY ANESTHESIOLOGY, LLC

Patrick D. McCarty, D.D.S. - Dentist Anesthesiologist



Medical History

Name _____ Home Phone _____

Address _____ Business Phone _____

City _____ State _____ Zip Code _____

Occupation _____ Social Security # _____

Date of Birth _____ Sex _____ Height _____ Weight _____

Closest Relative _____ Phone _____

If you are completing this form for another person, what is your relationship to the person? _____

Name of your Dentist _____ Phone _____

Name of your Physician _____ Phone _____

1. Do you have any allergies? Drug _____

Food _____

Other _____

2. Has there been any change in your health over the last year? _____

3. Are you now under the care of a physician? _____ if so, what is the condition being treated? _____

4. Have you had any serious illness, operation, or been hospitalized in the past 5 years?

5. Are you taking any medicines? Including non-prescription medicine? _____

If yes, what medications are you currently taking? _____

6. Are you taking any recreational drugs? _____

7. Do you have or had any of the following diseases or problems?

- a. Damaged heart valves or artificial valves, including heart murmur or Rheumatic heart disease? _____
- b. Knee or hip replacement, plastic or artificial arteries? _____
- c. Congenital heart defect or murmur? _____
- d. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis)?

8. Do you have chest pain upon exertion? _____

9. Are you ever short of breath after mild exercise or when lying down? _____

10. Do your ankles swell? _____

11. Do you have inborn heart defects? _____

12. Do you have a cardiac pacemaker? _____

13. Do you have an arrhythmia or an irregular heart beat? _____

- a. Has your physician ever told you to take antibiotics prior to dental therapy for a medical condition? _____

If yes, why? _____

14. Do you have any Respiratory Disease? _____

a. Asthma, Bronchitis, Pneumonia, Emphysema, Tuberculosis? _____

b. Chronic cough? _____

c. Hay Fever, Sinus trouble, allergies? _____

15. Do you smoke? Packs per day _____ How many years _____

16. Do you currently have:
- a. cold or flu? _____
 - b. Diabetes? _____
 - c. Persistent diarrhea or recent weight loss? _____
 - d. Hepatitis, jaundice or liver disease? _____
 - e. Fainting spells or seizures? _____
 - f. Thyroid problems? _____
 - g. Stomach ulcer or hyperacidity (reflux)? _____
 - h. Persistent swollen glands in neck? _____
 - i. Low blood pressure? _____
 - j. Sexually transmitted disease? _____
 - k. Epilepsy or other neurological problems? _____
 - l. Mental health conditions? _____
 - m. Cancer? _____
 - n. Problems with your immune system? _____
17. Do you have a history of alcoholism or drug dependence? _____
18. Have you had surgery or radiation treatment for a tumor or growth? _____
19. Are you allergic to or have you reacted adversely to: (please circle for any “yes”)
- a. Local anesthetic
 - b. Sedatives
 - c. Sleeping pills
 - d. Iodine
 - e. General anesthesia
 - f. Valium
 - g. Penicillin or other antibiotics
 - h. Sulfa drugs
 - i. Red wine
 - j. Demerol
 - k. Advil
 - l. Morphine
 - m. Barbiturates
 - n. Codeine
 - o. Ibuprofen
 - p. Eggs or soy
 - q. Other
20. Have you had any serious trouble associated with any previous dental treatment, surgery or any previous anesthetic? If so, please explain _____

21. Has anyone in your family had a bad reaction to anesthetic? _____

22. Do you have any disease, condition or problem not mentioned above? _____

23. Are you wearing contact lenses? _____

24. Are you now or is there any chance that you are pregnant? _____

25. Are you nursing? _____

26. Do you have any problems with your menstrual period? _____

27. Are you taking birth control pills? _____

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore, I have reviewed this health history carefully and have answered all questions truthfully to the best of my knowledge.

Signature of: (circle) Patient / Parent-Guardian

Date