

ADULT HEALTH HISTORY FORM (CONFIDENTIAL)

| Name | | Birth Date | | |
|---------------------|---|---------------------------|---------------------|--------|
| Last | First | | | |
| Address | | | | |
| Street | | | | |
| City | | State | Zip | |
| Tel # (Home) | (Cell) | Email | | |
| Sex | | Height | Weight | lbs. |
| Emergency Contac | t Name | | • | |
| If you are complet | ing this form for another pe | rson, what is your relat | ionship to that pe | rson? |
| | estions, circle YES or NO . Your | answers are for our recor | ds only and will be | |
| considered confiden | นลเ. our current physical health? | Γ\ | CCLLENT COOR | DOOD |
| - | ny change in your general healt | | | |
| | physical exam was on | | ••••• | TE3 NO |
| | er the care of a physician? | | | VEC NO |
| | ndition being treated? | | | 1L3 NO |
| | | | | |
| 6. Have you had any | illness or operation that requi | red hospitalization? | | YES NO |
| | lness or operation? | | | |
| | cough, or fever | | | |
| | our routine physical activity | | | |
| | e shortness of breath? At res | | Moderate exer | tion |
| | e you had any of the following valves, artificial heart valves, kr | | | |
| = | | | | VES NO |
| | defect(s) or murmur? | | | |
| = | isease: heart trouble, heart att | | | |
| | ertension), atherosclerosis, or | | | |
| | t pain upon exertion? | | | |
| | ell? | | | |
| • | of breath when you lie down, o | | | |
| · - | diac pacemaker/defibrillator?. | | = | - |
| • | rhythmia or an irregular heart | | | |
| | een diagnosed with sleep apne | | | |
| | ad Kawasaki's disease, Rheuma | | | |
| | tis, emphysema, persistent cou | | | |
| | | = | - : | |
| | eizures, or epilepsy? If YES, sta | | | |

| 17. Diabetes? Thyroid, pituitary, or adrenal gland condition? | YES NO |
|--|------------------------|
| 18. Hepatitis, jaundice, or liver disease? | YES NO |
| 19. Have you ever been told not to donate blood? If YES, why? | YES NC |
| 20. AIDS or tested positive for HIV? | YES NO |
| 21. Arthritis or inflammatory rheumatism? | YES NC |
| 22. Stomach ulcers? | YES NO |
| 23. Kidney trouble? | YES NO |
| 24. Low blood pressure? | YES NO |
| 25. Have you ever had a nervous breakdown or psychotherapy? | YES NO |
| 26. Do you have a history of alcoholism or drug dependence? | YES NO |
| 27. Have you ever taken any "recreational" drugs in the past such as cocaine, crac | k, marijuana, |
| LSD? | YES NO |
| a. If yes, what? When? | |
| 28. Do you have a history of smoking? | |
| a. If yes, how much per day? How many years have you smoked? | |
| 29. Do you have a history of drinking alcohol? | |
| a. If yes, how much do you drink per day averaged over the week? | |
| 30. Do you bleed or bruise easily? Or do you have hemophilia or von Willebrand D | |
| 31. Do you have any blood disorder, such as anemia or sickle cell anemia? | |
| 32. Have you ever received a blood transfusion? | |
| 33. Have you had surgery, x-ray treatment, or chemotherapy for a tumor, cancer, | |
| condition? | |
| 34. Please list all medications you are currently taking | |
| 35. Please list all allergies to medication, latex, or food | |
| 36. Have you or a close relative ever had a bad reaction to any anesthetic drug? | YES NO |
| 37. Have you ever had complications during a previous anesthetic? | |
| 38. Do you have any disease, condition, or problem not mentioned above? | |
| a. If YES, what? | |
| 39. WOMEN: | |
| a. Is there any possibility that you are pregnant? | YES NO |
| b. Are you a nursing mother? | YES NO |
| The information on this questionnaire is accurate to the best of my knowledge and | d that withholding any |
| information could result in injury or death. I understand that the information will | <u> </u> |
| of confidence and it is my responsibility to inform Dr. Jinsoo Kim of any changes in | |
| the earliest possible time. | , |
| | |
| Signature of Patient Da | ate |
| Reviewed by: Jinson Kim DDS Di | ate |