HDA Hamilton Dental Associates PA

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Phone (609) 689-1212

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Hopewell Campus
1300 Merrill Lynch Drive, Suite 301
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Phone (609) 274-8484

Dentistry for Children & Adolescents
*Sidney Whitman, DDS
*Arthur Fields, DDS
*Irving Djeng, DDS
*Otto Choi, DDS
*Maria Graye, DMD
*Lauren Levine, DMD
*Dana Romano, DMD

Adult Dentistry
Kevin Collins, DDS
Deolinda Reverendo, DMD
Khurrum Sheikh, DMD
Claire Saxena, DMD
Ridhi Ghetia, DMD
David Lepelletier, DMD
Katrina Verendia, DMD

Orthodontics
Michael DeLuca, DMD
*Matthew Etter, DMD
*Kerri Odhner, DMD

Periodontics
Steven Milstein, DDS*
Amanda Hochstein, DDS

Oral Surgery
George Sandau, DMD, MD

Endodontics
Steven Ryu, DMD
*Joseph Luzzo, DMD

*NJ Certified Specialists

www.hamiltondental.com

ORAL SURGERY HEALTH HISTORY

Date: _____

Name: _____ Phone# _____

Height: _____ Weight: _____ Age: _____

Have you had or do you currently have any of the following conditions:

	Yes	No		Yes	No
Heart valve condition/murmur/surgery	( )	( )	Irregular heartbeat? pacemaker/defribillator	( )	( )
History of rheumatic fever?	( )	( )	Atrial Fibrillation,Heart block, palpitations?	( )	( )
Coronary artery disease/ Stents?	( )	( )	Heart failure/disease, Heart/Bypass surgery?	( )	( )
Chest pain or Angina?	( )	( )	Kidney or bladder condition (Nephritis)	( )	( )
Heart attack or Stroke, TIA history	( )	( )	Dialysis? Kidney condition or failure?	( )	( )
High or Low blood pressure	( )	( )	Diabetes or low blood sugar?	( )	( )
History of Head Injury or concussion?	( )	( )	IBD, inflammatory bowel disease?	( )	( )
Thyroid condition?	( )	( )	Ulcerative Colitis or Crohn's disease?	( )	( )
History of Headaches or Migraines?	( )	( )	Rheumatoid Arthritis, Lupus, Scleroderma?	( )	( )
Ulcer, Reflux, gastritis, esophagitis?	( )	( )	Hepatitis?, Jaundice or Liver condition ?	( )	( )
Pneumonia, bronchitis, cough?	( )	( )	History of Blood transfusions?	( )	( )
Asthma, Eczema, Allergic Rhinitis?	( )	( )	Blood disorder / Anemia?	( )	( )
Sinusitis / Nasal Problems	( )	( )	Do you bruise easily? Nosebleeds?	( )	( )
Snoring or Sleep apnea?, CPAP?	( )	( )	Bleeding tendency / Hemophilia	( )	( )
Difficulty breathing or short of breath?	( )	( )	Gall bladder trouble/surgery?	( )	( )
Tuberculosis?	( )	( )	Vertigo, Dizziness, Tinnitus, hear ringing?	( )	( )
COPD or Emphysema?	( )	( )	Osteoarthritis/other joint condition?(Gout)	( )	( )
Do you SMOKE? Or Chew tobacco?	( )	( )	Osteoporosis /Osteopenia?	( )	( )
Recreational/Illicit drug use/abuse?	( )	( )	Malignant Hyperthermia?	( )	( )
Enzyme deficiency?	( )	( )	History of MRSA infection?	( )	( )
Immuno- suppressed/compromised	( )	( )	Sexually Transmitted diseases? or HIV?	( )	( )
Infectious disease, Transplant ?	( )	( )	Autism?, Autism spectrum?, Tourettes?	( )	( )
CHRONIC PAIN management?	( )	( )	Developmental delay?	( )	( )
Delay in wound healing?	( )	( )	Anxiety? Depression? ADD/ADHD?	( )	( )
Chronic fatigue / night sweats?	( )	( )	Schizophrenia? Bipolar or Mood disorder?	( )	( )
Epilepsy or seizures?	( )	( )	Alcohol Abuse/Dependency ?	( )	( )
Insomnia / Narcolepsy?	( )	( )	Medication or Drug Abuse/Dependency?	( )	( )
Cancer, chemotherapy, radiation?	( )	( )	Spine or Back injury or surgery?	( )	( )
Fainting or Syncope?	( )	( )	Sensitive Gag Reflex? History of Nausea?	( )	( )
Gastric Bypass surgery?	( )	( )	Orthopedic or joint surgery (fracture repair)	( )	( )
Numbness? Weakness?	( )	( )	Previous Jaw/Facial fractures or surgery?	( )	( )

Are you under the care of a physician now? Why? _____
Have you ever been hospitalized? Why? _____
Any previous sedations or general anesthesia? Why? _____

	Yes	No
Have you or a family member had any problems with any type of anesthesia in the past?		
Have you had any problems with previous dental extractions or a bad dental experience?		
If yes, please explain: _____		
Any pain or clicking of your jaw, or grinding or clenching, or difficulty opening your mouth?		
Do you need rest of become short of breath when climbing a flight of stairs?	( )	( )
If you are female: (A) Do you have regular menstrual periods?	( )	( )
(B) Are you pregnant ? weeks?_____ Are you currently nursing a child?	( )	( )
Have you ever taken or been prescribed steroids, laxatives, diuretics, or amphetamines?	( )	( )
Do you suffer from an eating disorder or body dysmorphic disorder? (Anorexia, Bulimia)	( )	( )
Were you ever prescribed or have you ever taken any bone density/osteoporosis medications?	( )	( )
Bisphosphonates? (Aredia, Zometa, Fosamax, Actonel, Reclast, Boniva, Xegva, Prolia?)	( )	( )
Blood thinner medications? (Aspirin,Coumadin, Plavix, Pradaxa, Xarelto, Aggrastat, Persantine?)	( )	( )
Are you allergic to any foods or medications? (Aspirin, penicillin, sulfa, codeine, other?)	( )	( )

Are you currently taking any kind of medication, drug, pills? Over The Counter or Prescription?
Please list: _____

Signature: _____ Date: _____