Steven M. Haber, D.D.S.
DIPLOMATE, AMERICAN BOARD OF
ORAL AND MAXILLOFACIAL SURGERY
NJ SPECIALTY PERMIT #2791

PATIENT'S MEDICAL HISTORY

(Please circle your answers where appropriate.)

Date: ____/____/____

Patient's Name: _____ Sex: Male Female
Last First Middle

Home Address: _____
Number and Street City State Zip Code

Home Telephone: _____ Cell: _____ Fax: _____

Marital Status: Married Single Divorced Widowed Date of Birth: _____ Age: _____

Social Security # _____ Driver's License # _____

If the patient is under the age of 18 years:
Parent's or Guardian's Name: _____

Occupation or Position: _____ Business Telephone: ( ) _____
Area Code

Name and Address of Business _____

Who referred you to Dr. Haber? _____

General Dentist's Name: Dr. _____

Physician's Name and Address: Dr. _____

Date of last physical examination: ____/____/____ Height: _____ Weight: _____ lbs.

Please indicate your present medical health: Excellent Good Fair Poor

Have you previously been treated by Dr. Haber? _____	YES	NO
Are you now under a physician's care? _____	YES	NO
Have you been seen and/or treated by a physician within the past two years? _____	YES	NO
Have you been a patient in a hospital within the past five years? _____	YES	NO
Do you have any prosthetic (implanted) joints, heart valves, vascular stents or grafts? _____	YES	NO
Have you ever had radiotherapy (radiation treatments)? _____	YES	NO
Are you now taking or supposed to be taking any medicines or drugs? _____	YES	NO
Are you taking or supposed to be taking any Anticoagulants (Blood Thinners)? _____	YES	NO
Have you ever taken a Bisphosphonate drug (Fosamax, Actonel, Zometa, Boniva, Aredia, Reclast)?_____	YES	NO
Are you taking any herbal products, homeopathic medicines, dietary supplements or over-the-counter medicines?	YES	NO
Have you taken any prescription medicines within the past six months? _____	YES	NO
Have you taken any medicine containing Aspirin or Aspirin-like ingredients (NSAID's) within the past ten days?	YES	NO
Are you allergic to penicillin, latex, codeine, local anesthetics or any other drugs or medicines? _____	YES	NO
Do you use any nasal sprays?	YES	NO
Are you now or have you EVER been addicted to OR abused any medicines, drugs or substances? _____	YES	NO
Have you been exposed to anyone who has OR do you have Acquired Immune Deficiency Syndrome (AIDS)?	YES	NO
Do you now have or have you had a cold, sniffles, running nose, stuffed nose, post-nasal drip, sore throat, asthma attack, shortness of breath, phlegm, sneezing, allergies, wheezing, chest congestion or cough within the past seven days? __	YES	NO
Do you chew or smoke tobacco or other substances? _____	YES	NO
Have you or any family member had a problem during a previous anesthesia or dental treatment? _____	YES	NO

When was the last time you ate or drank anything?
Today _____ A.M. _____ P.M.
Yesterday _____ A.M. _____ P.M.

Do you wear dentures (removable false teeth)? _____	YES	NO
Are you wearing contact lenses? Soft or Hard? _____	YES	NO
(Women) Are you breastfeeding or pregnant now or is there any chance that you might be pregnant? _____	YES	NO

Have you EVER had or been treated for: (Please answer all questions.)

high or low blood pressure _____	YES	NO	bleeding or blood clotting problems _____	YES	NO
stroke _____	YES	NO	tuberculosis or lung diseases _____	YES	NO
rheumatic fever _____	YES	NO	asthma _____	YES	NO
heart murmur or mitral valve prolapse _____	YES	NO	sinus trouble or hay fever _____	YES	NO
chest pain or angina _____	YES	NO	glaucoma _____	YES	NO
heart trouble _____	YES	NO	arthritis _____	YES	NO
cardiac pacemaker _____	YES	NO	hepatitis or other liver disease _____	YES	NO
psychiatric or emotional problems _____	YES	NO	jaundice _____	YES	NO
epilepsy, seizures or fainting spells _____	YES	NO	thyroid disorder _____	YES	NO
diabetes (high blood sugar) _____	YES	NO	kidney problems _____	YES	NO
ulcers _____	YES	NO	venereal disease (Syphilis, Gonorrhea,		
anemia _____	YES	NO	Chlamydia or Herpes) ____	YES	NO
porphyria_____	YES	NO	sickle cell trait or disease_____	YES	NO

DO YOU HAVE ANY OTHER MEDICAL CONDITION OR PROBLEM NOT RECORDED ABOVE? _____ YES NO

I understand the importance of a truthful and complete Medical History to assist the doctor in providing the best care. I have discussed my Medical History with Dr. Haber.

Patient's Signature: _____ Date: ____/____/____

If the patient is under the age of 18 years: Parent's or Guardian's Signature: _____Date:____/____/____