

Gulf Coast Oral and Facial Surgery, PA

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Toll-Free Watts Line 1-800-325-5925

1. Are you in good health? Y N
2. Are you now under a physician's care? Physician's name Y N
3. Are you taking any medication(s) including nonprescription? Y N List:

4. Date of last physical exam
5. Have you had any serious illnesses, surgeries or hospitalizations? Y N Explain:

6. Allergies? List:
7. Are you allergic to or had reaction to:
 - Local anesthetic (novocaine, etc.) Y N
 - Antibiotics (penicillin, etc.) Y N
 - Pain Medicine Y N
 - Sedatives Y N
 - Latex / rubber products Y N
8. Have you had any adverse effects from dental treatment? Y N
9. Do you smoke or chew tobacco? Y N
10. Have you ever sought professional care for drug abuse, alcoholism or emotional disorders? Y N
11. Have you or your family had any previous problems with anesthesia/sedation?
12. Are you now or have you ever taken any of the following medications for osteoporosis?
 - Oral Biphosphonates: Fosamax, Actonel, Didronel, Boniva
 - IV Biphosphonates: Aredia, Zometa, Reclast
13. Have you had a previous history of tempromandibular joint disease (TMJ)?
14. Do you have or have you had:

	Y	N		Y	N
HEART DISEASE			LIVER DISEASE		
*Rheumatic Fever			Hepatitis (Yellow Jaundice)		
*Rheumatic Heart Disease			Cirrhosis		
*Heart Murmur			DIABETES (Sugar)		
*Mitral Valve Prolapse			Do you take insulin?		
High Blood Pressure			THYROID DISEASE		
Angina			GLAUCOMA		
Heart Attack (Coronary)			SEIZURE DISORDER		
*Heart Defects			BLEEDING PROBLEMS		
Stroke			ANEMIA		
Abnormal Electrocardiogram (EKG)			AIDS or HIV Positive		
Heart Surgery			SICKLE CELL ANEMIA or TRAIT		
*Pacemaker			TUMOR or CANCER		
LUNG DISEASE			RADIATION (Cobalt) THERAPY		
Bronchitis			*HIP JOINT SURGERY		
Asthma			NEUROLOGICAL DISORDER		

15. Women: Are you pregnant? Y N
 - Are you taking birth control pills? Y N
 - Are you taking hormone replacements? Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

Signature of Person Completing Health History

Date

Dr's. Initials