paul e. coggins
DDS, MPH
welcome

paulcogginsdds.com

Patient's name _____
Last First Initial Date of Birth

Please mark the appropriate answer. If you don't know the correct answer, please write "Don't know."

1. Your physician's name _____
   Practice name _____
   Address City, State, Zip _____
2. Are you under a physician's care currently? ❑ Yes ❑ No
   Since when? _____ Why? _____
3. When was your last physical exam? _____
4. Are you taking any medications? If yes, please list _____ ❑ Yes ❑ No
   _____
5. Do you routinely take health-related supplements? (vitamins, etc.) ❑ Yes ❑ No
   If yes, please list _____
6. Are you allergic to any medicines or substances? ❑ Yes ❑ No
7. Do you have any other allergies? What? _____ ❑ Yes ❑ No
8. Are you sensitive to any metals or latex? ❑ Yes ❑ No
9. Are you pregnant or suspect that you may be? ❑ Yes ❑ No
10. Have you ever been treated for or been told you might have heart disease? ❑ Yes ❑ No
11. Do you have a pacemaker or an artificial heart valve? ❑ Yes ❑ No
12. Do you have high or low blood pressure? (please circle which one) ❑ Yes ❑ No
13. Have you ever had a serious illness or major surgery? ❑ Yes ❑ No
    If so, explain _____
14. Have you ever had radiation treatment or chemo therapy? ❑ Yes ❑ No
15. Have you ever taken Fosamax, Zometa, Aredi, Bonita, or any other oral or intravenous treatments (bisphosphonates) for bone tumors, excessive calcium in your blood or osteoporosis? ❑ Yes ❑ No
16. Do you have inflammatory disease such as arthritis or rheumatism? ❑ Yes ❑ No
17. Do you have any artificial joints or prosthesis? ❑ Yes ❑ No
    If so, when? _____ Area of replacement _____
18. Do you have any blood disorders such as anemia, leukemia, etc.? ❑ Yes ❑ No
19. Have you ever bled excessively after being cut or injured? ❑ Yes ❑ No
20. Do you have any stomach problems? ❑ Yes ❑ No
21. Do you have any kidney problems? ❑ Yes ❑ No
22. Do you have any liver problems? ❑ Yes ❑ No
23. Are you diabetic? If yes, Type 1 or Type 2 (circle one) ❑ Yes ❑ No
24. If yes, is your diabetes controlled? ❑ Yes ❑ No
25. Do you have fainting or dizzy spells? ❑ Yes ❑ No
26. Do you have asthma? ❑ Yes ❑ No
27. Do you have epilepsy or seizure disorders? ❑ Yes ❑ No
28. Have you tested HIV positive? ❑ Yes ❑ No
29. Have you had or do you test positive for hepatitis? ❑ Yes ❑ No
30. Do you or have you had T.B.? ❑ Yes ❑ No
31. Do you smoke, chew, use snuff, or any other forms of tobacco? ❑ Yes ❑ No
32. Have you taken any prescription drugs like fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ❑ Yes ❑ No
33. Do you have any disease or condition that is not listed? If so, explain ❑ Yes ❑ No
    _____
    _____
34. Is there anything else we should know about your health that we have not covered? _____ ❑ Yes ❑ No
35. Would you like to speak to Dr. Coggins privately about any problem? ❑ Yes ❑ No

Additional Info

I certify that the above information is complete and accurate.

Patient's/Guardian's signature _____ Date _____

Dr. Coggins' signature _____ Date _____

ANESTHESIA

MEDICAL HISTORY

MED ALERT