KENNETH L. ODINET, D.D.S., M.D. **HEALTH HISTORY**

Health problems that you may have or medication you are on may have an important interrelationship with the overall care that you receive
Please answer the following questions to the best of your knowledge. The answers are for our records only and will be considered confidential

Patient Name: ______________________ **Date:** ______________

Referring Doctor or Source: ______________ Reason for Visit: ______________
Primary Care ______________ Cardiologist ______________ OBgyn ______________

MEDICAL HISTORY: Please check all the medical conditions that you have or have ever had:

High Blood Pressure
Lung Disease (Emphysema, TB, Asthma)
Liver Disease (Jaundice, Hepatitis)
Kidney Disease (Stones)
Chemotherapy
Bleeding Complications/Tendencies
Breast Disease
Anesthesia Problems (High fever, Nausea)
Diabetes
Heart Attack
Stroke
Digestive Problems (Acid Reflux/Ulcer)
Radiation
Keloids (Scars)
Sexually Transmitted Disease
Contact Lenses/ Glasses
Other: ______________________________

List all operations and the year performed: ______________________

Operation: ______________________ Year ______________
Operation: ______________________ Year ______________
Operation: ______________________ Year ______________

Family History: (Please specify: parent, sibling, grandparent, maternal/paternal) Put stars: *
High Blood Pressure: ______________ Who? ______________
Cancer: Type: ______________ Who? ______________

____

Social History:
Do you smoke? ________ Have you ever smoked? ________ Amount: ________
Do you drink alcohol? ________ Frequency? ______________
Do you use social drugs? ________ What kind? ________ Frequency? ________
Is there a chance that you may be pregnant? ______________
Have you ever had steroid therapy? ______________ What type? ________

Weight: ________ Height: ________ Drug allergies: ________
______________________ Reaction: ________

List all Medications you are taking, frequency, and amount: Include all over the counter medication:
(Please provide a list if you have one already made to our receptionist)

____
____
____

Patient Signature: ______________________ Date: ________

M.D. Signature: ______________________ Date: ________

RELEASE OF MEDICAL RECORDS

Kenneth L. Odinet, D.D.S., M.D.
200 Beaullieu Dr., Bldg. 6
Lafayette, LA 70508

AUTHORIZATION TO TRANSFER RECORDS

I, ________________________________, hereby request the transfer of a copy of all my medical records and reports be sent to:

KENNETH L. ODINET, DDS, MD
200 BEAULLIEU DRIVE
BUILDING 6
LAFAYETTE, LA 70508
(337) 234-8648
(337) 233-0244 FAX

________________________________ ________________________________
Signature of Patient/Guardian Date

____
Date of Birth

____

____
Address