

HEALTH HISTORY

To our patients. Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit: _____

Pain scale (0=no pain, 10=severe pain)  (please circle one)

Height _____ Weight _____ Age _____

Answer all questions by circling Yes (Y) or No (N)

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. Are you in good health?.....Y N</p> <p>2. Has there been any change in your general health in the past year?.....Y N</p> <p>3. Date of last physical exam _____</p> <p>4. Are you now under a physician's care for a particular problem?.....Y N</p> | <p>5. Have you ever had any serious illnesses, operations or hospitalizations?.....Y N</p> <p>If so, describe: _____</p> <p>_____</p> <p>_____</p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|

HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....				Yes	No	NOTES	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....				Yes	No	NOTES
1	Chest Pain, angina?						27	Type I diabetes?					
2	Heart attack(s)?						28	Type II diabetes?					
3	Damaged heart valves / Heart valve disease?						29	Kidney disease?					
4	Rheumatic Fever?						30	Are you on dialysis?					
5	Heart valve replacement surgery?						31	Rheumatoid arthritis?					
6	Heart surgery including bypass surgery and/or stent placement?						32	Osteoporosis or other disease of the bone?					
7	Irregular heart beat? (ex. Atrial fibrillation)						33	Stomach ulcers or colitis?					
8	Cardiac pacemaker?						34	Gastric reflux disease?					
9	Prosthetic joint? (ex. Hip, knee, etc.)						35	Contagious diseases?					
10	Pneumonia?						36	Immunosuppressive disease (ex. Lupus)					
11	Asthma?						37	History of immunosuppressive drugs? (ex. Steroids, methotrexate)					
12	Bronchitis?						38	History of cancer?					
13	Emphysema / COPD?						39	Radiation or chemotherapy?					
14	Hay fever / Sinus problems?						40	Chronic pain / Fibromyalgia					
15	Tuberculosis?						41	Are you on a diet / taking diet pills?					
16	Blood transfusion?						42	Eye disease / Glaucoma?					
17	Blood disorders? (ex. Anemia, thrombocytopenia)						43	Contact lenses?					
18	Bruise / bleed easily						44	Pain, clicking, popping of the jaw joint?					
19	Blood clots in your legs?						45	Malignant hyperthermia?					
20	Liver Disease?						46	Do you smoke or chew tobacco?					
21	Hepatitis? A B C						47	History of alcohol abuse?					
22	HIV or AIDS?						48	History of illegal drug and/or perscription drug abuse?					
23	Seizures, convulsions, epilepsy?						49	Sexually transmitted diseases?					
24	Stroke / TIA?						50	Psychological disorders: OCD, bipolar, chizophrenia, depression?					
25	History of headaches?						51	Do you have any other disease not listed above?					
26	Thyroid disease?						52	Family history of substance abuse?					

MEDICATION						
ARE YOU NOW TAKING...		Yes	No	LIST DRUG NAME(S)	ARE YOU NOW TAKING...	
53	Anticoagulants? (Ex. Coumadin, Plavix, Pradaxa, Xarelto)				59	Please list all other medications taken including over the counter, herbs and vitamins
54	Asprin, NSAID's (Ex. Motrin, Aleve)?					
55	High blood pressure medications?					
56	Insulin or oral anti-diabetic drugs?					
57	Steroids (Ex. Prednisone)?					
58	Bisphosphonates (ex. Fosamax, Boniva, Zometa, Aredia)					

ALLERGIES						
ARE YOU ALLERGIC TO OR HAD A REACTION TO...		Yes	No	REACTION	ARE YOU ALLERGIC TO OR HAD A REACTION TO...	
60	Local anesthetics?				68	Please list all additional allergies
61	Codeine or other narcotics?					
62	Motrin / Ibuprofen / Asprin?					
63	Valium / Midazolam or other benzo-diazapenes?					
64	Latex?					
65	Sulfites? (preservatives)					
66	Penicillin / Amoxicillin?					
67	Sulfa antibiotics?					

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? Yes No

If yes, please explain: _____

Is there a family history of: 301. **Cancer** Yes No 302. **Diabetes** Yes No 303. **Heart Disease** Yes No 304. **Anesthetic Problems** Yes No

If yes, please explain: _____

(MEN skip to line 73)		WOMEN COMPLETE THIS SECTION					
69	Is there a possibility of pregnancy?	Yes	No	71	Are You Nursing?	Yes	No
70	Estimated delivery date ____/____/____			72	* Are you taking birth control pills?	Yes	No
<p>*I understand that antibiotics (such as penicillin) and other medications may alter the effectiveness of birth control pills. Therefore, I understand that I will need to use some additional form of birth control for one complete cycle of birth control pills after the course of antibiotics and other medication is completed. Consult your physician/gynecologist for assistance regarding other methods of birth control.</p> <p>Initial _____</p>							

73. I certify that I have read and I understand the questions above. I acknowledge that my questions, if any about the Inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his/ her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____ Date: _____
 (Parent or Guardian if minor)