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)

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

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE...........	Yes	No	NOTES
1	Chest Pain, angina?			
2	Heart attack(s)?			
3	Damaged heart valves / Heart valve disease?			
4	Rheumatic Fever?			
5	Heart valve replacement surgery?			
6	Heart surgery including bypass surgery and/or stent placement?			
7	Irregular heart beat? (ex. Atrial fibrillation)			
8	Cardiac pacemaker?			
9	Prostetic joint? (ex. Hip, knee, etc.)			
10	Pneumonia?			
11	Asthma?			
12	Bronchitis?			
13	Emphsysema / COPD?			
14	Hay fever / Sinus problems?			
15	Tuberculosis?			
16	Blood transfusion?			
17	Blood disorders? (ex. Anemia, thrombocytopenia			
18	Bruise / bleed easily			
19	Blood clots in your legs?			
20	Liver Disease?			
21	Hepatitus? A B C			
22	HIV or AIDS?			
23	Seizures, convulsions, epilepsy?			
24	Stroke / TIA?			
25	History of headaches?			
26	Thyroid disease?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE...........	Yes	No	NOTES
27	Type I diabetes?			
28	Type II diabetes?			
29	Kidney disease?			
30	Are you on dialysis?			
31	Rheumatoid arthritis?			
32	Osteoporosis or other disease of the bone?			
33	Stomach ulcers or colitis?			
34	Gastric reflux disease?			
35	Contagious diseases?			
36	Immunosuppressive disease (ex. Lupus)			
37	History of immunosuppressive drugs? (ex. Steroids, methotrexate)			
38	History of cancer?			
39	Radiation or chemotherapy?			
40	Chronic pain / Fibromyalgia			
41	Are you on a diet / taking diet pills?			
42	Eye disease / Glaucoma?			
43	Contact lenses?			
44	Pain, clicking, popping of the jaw joint?			
45	Malignant hyperthermia?			
46	Do you smoke or chew tobacco?			
47	History of alcohol abuse?			
48	History of illegal drug and/or perscription drug abuse?			
49	Sexually transmitted diseases?			
50	Psychological disorders: OCD, bipolar, chizophrenia, depression?			
51	Do you have any other disease not listed above?			
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 leist 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 possibilty of pregnancy?	Yes	No		71	Is there a poddibilty of pregnancy?	Yes	No
70	Estimated delivery date ______/______ /______				72	* Are you taking birth control pills?	Yes	No

*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.

Initial ____________________

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)

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