Health History

To our patients. Although oral surgeons primarily treat the area in and around your mouth, your mouth is a 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 question. Your answers are for our records only and will be considered confidential.

Patients Name: ____

Reason for today's office visit: ____

		Yes	No
1.	Are you in good health? _______Yes _______No Height ____________________ Weight____________		
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? _____Yes _____No Date of last visit: ____________________ If so, for what are your being treated? ____________________________		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
5.	Do you have unhealed injuries or inflamed area, growths or sore spots in or around your mouth?______ If so describe where ____________________		
6.	Have you had a prosthetic joint/implant?______ if so, describe where ____________________		
7.	Have you had a heart valve replacements, vascular graft or stent?	❑	❑

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE	Yes	No	NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE	Yes	No	NOTES
8.	Rheumatic fever?				33.	Stroke?			
9.	Damaged heart valves/mitral valve proplapse?				34.	Thyroid trouble?			
10	Heart murmur?				35.	Diabetes?			
11.	High blood pressure?				36.	Low blood sugar?			
12.	Low blood pressure?				37.	Kidney trouble?			
13.	Chest pain, angina?				38.	Are you on dialysis?			
14.	Heart attack(s)?				39.	Hiatal Hernia / Acid Reflux			
15	Irregular heart beat?				40.	Stomach ulcers			
16.	Cardiac pacemaker?				41.	Contagious diseases?			
17.	Heart surgery?				42.	V.D. / HIV / AIDS			
18.	Bronchitis, chronic cough?				43.	Problems with the immune system?			
19.	Asthma?				44.	Delay in healing?			
20.	Hay fever / sinus problems?				45.	A tumor or growth?			
21.	Tuberculosis?				46.	X-ray treatment / chemotherapy?			
22.	Emphysema?				47.	Chronic fatique / night sweats?			
23.	Difficult breathing / other lung trouble?				48.	Are you on a diet?			
24.	Blood transfusion?				49.	Contact lenses?			
25.	Blood disorder such as anemia?				50.	Eye disease / glaucoma?			
26.	Sickle Cell Disease / Trait				51.	Sleep Apnea			
27.	Bleeding tendency (abnormal bleed)?				52.	A removable dental appliance?			
28.	Jaundice, hepatitis or liver disease?				53.	Pain & clicking of jaws when eating?			
29.	Frequent nose bleeds				54.	Malignant hyperthermia.			
30.	Motion sickness				55.	Do you smoke or use smokeless tobacco?			
31.	Fainting spells				56.	A history of drug use			
32.	Convulsions, epilepsy				57.	Do you drink alcohol?			

MEDICATION

List all prescription and non-prescription medications and supplements (herbal or homeopathic.)

ALLERGIES

List all medication and environmental allergies including latex

WOMEN

	YES	NO		YES	NO
61. Is there a possibility of pregnancy?			63. Are you nursing?		
62. Estimated delivery date? ___/ ___/ ___			64. Are you taking birth control pills?		

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

List any other health conditions not already noted.

Physicians	Name	Phone #
Medical Doctor		
Cardiologist		

Previous Surgeries	Date	Anesthesia - type Complication

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: X______________________ Reviewed by: X______________________ Date: X__________
(Parent or Guardian if minor)

Have there been any changes in your health history since your previous visit? Yes ____ No ____

Signature of patient: X______________________ Reviewed by: X______________________ Date: X__________
(Parent or Guardian if minor)