HEALTH HISTORY

Patient Name:: _____ _____ Birth Date: _____ Today's Date _____
FIRST NAME LAST NAME

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 medications 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 visit? _____

		YES	NO
1	***Height*** _____ ***Weight*** _____ Are you in good health?	☐	☐
2	Have there been any changes in your general health in the past year?	☐	☐
3	Are you under the care of a physician? ***Date of last visit*** _____ ***If so, for what are you being treated?*** _____	☐	☐
4	Have you had any illness, operation or been hospitalized in the past five years? ***If so, describe*** _____	☐	☐
5	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? ***If so, describe where*** _____	☐	☐
6	Do you have a prosthetic joint / implant? ***If so, describe where*** _____	☐	☐
7	Have you had a heart valve replacement or vascular graft?	☐	☐
8	Have you ever had general anesthesia?	☐	☐
9	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	☐	☐
10	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment	☐	☐

	HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
11	Rheumatic fever?		
12	Damaged heart valves? ☐ Mitral valve prolapse ☐ Other		
13	Heart murmur?		
14	High blood pressure?		
15	Low blood pressure?		
16	Chest pain / angina?		
17	Heart attack(s)?		
18	Irregular heart beat?		
19	Cardiac pacemaker?		
20	Heart surgery?		
21	Pneumonia, bronchitis, chronic cough?		
22	Asthma?		
23	Hay fever / sinus problems?		
24	Snoring?		
25	Sleep apnea / CPAP?		
26	Difficult breathing / other lung trouble?		
27	Tuberculosis?		
28	Emphysema?		
29	Do you smoke? If so, number of packs a day _____		
30	Do you use chewing tobacco?		
31	Blood transfusion?		
32	Blood disorder such as anemia?		
33	Bruise easily?		
34	Bleeding tendency / abnormal bleed?		
35	Hepatitis, jaundice, or liver disease?		
36	Infections mononucleosis?		
37	Gallbladder trouble?		
38	Fainting spells?		
39	Convulsions / epilepsy?		
40	Stroke?		

	HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
41	Thyroid trouble?		
42	Diabetes?		
43	Low blood sugar?		
44	Kidney trouble?		
45	High cholesterol?		
46	Are you on dialysis?		
47	Swollen ankles / arthritis / joint disease?		
48	Osteoporosis / osteopenia?		
49	Osteonecrosis?		
50	Acid reflux?		
51	Stomach / GI troubles / ulcers / IBS / colitis?		
52	Contagious disease?		
53	Sexually transmitted diseases?		
54	Problems with immune system? Possibly from medication/surgery, etc.		
55	Delay in healing?		
56	A tumor or growth?		
57	Cancer? What type? _____		
58	Radiation / Chemotherapy? When? _____		
59	Chronic fatigue / night sweats?		
60	Are you on a diet?		
61	A history of alcohol abuse?		
62	A history of drug abuse?		
63	Contact lenses?		
64	Eye disease / glaucoma?		
65	Mental health problems: ☐ Anxiety ☐ Depression ☐ Psychiatric Disorder ☐ ADHD ☐ Other		
66	A removable appliance?		
67	Pain or clicking of jaws when eating?		

	ARE YOU NOW TAKING:	YES	NO
68	Any kind of medication, drug, pills?		
69	Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba, Aggrenox, Pradaxa, Fish Oil)?		
70	Have you ever taken diet pills?		
71	Any natural product, herbal supplement or homeopathic remedy?		
72	Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast or Evista in the past 12 years?		
73	Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:		

74 Please list any medications you are currently taking:

Medication	Dosage	Frequency

	WOMEN ONLY: (QUESTIONS 74-77)	YES	NO
75	Is there a possibility of pregnancy?		
76	Expected delivery date:		
77	Are you nursing?		
78	Are you taking birth control pills? **Note:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.		

	ARE YOU ALLERGIC TO, OR HAD A REACTION TO	YES	NO
79	Local anesthetic (numbing meds.)?		
80	Penicillin?		
81	Other antibiotics?		
82	Sulfa drugs?		
83	Sodium pentothal / Valium / other tranquilizers?		
84	Aspirin?		
85	Amoxicillin?		
86	Codeine or other narcotics?		
87	Latex?		
88	Soy?		
89	Eggs / yolk?		
90	Sulfites?		
91	Do you have any known allergies?		
92	Please list any allergies other than drug allergies:		
93	Please list any other medication or antibiotic you are allergic to:		

Is there any condition concerning your health that the Doctor should be told about? ☐ Yes ☐ No
If **Yes**, describe:

Do you wish to speak to the Doctor privately about anything? ☐ Yes ☐ No

Is this visit related to an accident?
If **Yes**, what type of accident? ☐ Automobile ☐ Work ☐ Other

Date of injury: _____

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ☐ Yes ☐ No

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 doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ X _____
Signature of Patient (Parent or Guardian if Minor) **Date**