



HEALTH HISTORY FORM

Patient Name: _____ Date: _____

To our patients: Although oral and maxillofacial surgeons primarily treat the area in and around your mouth and face, 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 inter-relationship 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:

Are you in good health? ___ Yes ___ No Height _____ Weight _____

Have there been any changes in your general health in the past year? ___ Yes ___ No

Are you under the care of a physician? ___ Yes ___ No

If so, for what are you being treated? _____

Are you under the care of a dentist? ___ Yes ___ No Date of last visit: _____

If so, for what are you being treated? _____

Have you had an illness, operation or been hospitalized in the past five years? _____

Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?

If so, describe where _____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE? If yes, explain.

Do you have a prosthetic joint?	Yes	No
Have you had a heart valve replacement?	Yes	No
Have you had a vascular graft?	Yes	No
Rheumatic fever?	Yes	No
Damaged heart valves/mitral valve prolapse?	Yes	No
Heart murmur?	Yes	No
High blood pressure?	Yes	No
Low blood pressure?	Yes	No
Chest pain, angina?	Yes	No
Heart attack(s)?	Yes	No
Irregular heart beat?	Yes	No
Cardiac pacemaker?	Yes	No
Heart surgery?	Yes	No
Bronchitis, chronic cough?	Yes	No
Asthma?	Yes	No
Hay fever/sinus problems?	Yes	No
Tuberculosis?	Yes	No
Emphysema?	Yes	No
Difficult breathing/other lung trouble?	Yes	No
Blood transfusion?	Yes	No
Blood disorder such as anemia?	Yes	No
Bruise easily?	Yes	No
Bleeding tendency (abnormal bleed)?	Yes	No
Jaundice, hepatitis or liver disease?	Yes	No
Infectious mononucleosis?	Yes	No
Gallbladder trouble?	Yes	No
Fainting spells?	Yes	No
Stroke?	Yes	No
Thyroid trouble?	Yes	No
Diabetes?	Yes	No
Low blood sugar?	Yes	No
Kidney trouble?	Yes	No

Date _____

Date _____



Are you on dialysis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swollen ankles, arthritis or joint disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach ulcers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contagious diseases?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV / AIDS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexually transmitted diseases?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problems with the immune system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Delay in healing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A tumor or growth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
X-Ray treatment / chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic fatigue / night sweats?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you on a diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A history of druge abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A history of alcohol abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye disease / glaucoma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental health problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A removable dental appliance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain & clicking of jaws when eating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Malignant hyperthermia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you are having surgery today, have you had anything to eat or drink in the last 6-8 hours?
 Yes No

Who is driving you home? _____

Are you taking any blood thinners? (i.e. Coumadin, Aspirin, Advil)?
 Yes No

Are you taking diet pills? Yes No

Are you taking any tranquilizers? Yes No

Are you taking any kind of natural product, herbal supplement, or homeopathic remedy?
 Yes No

Please list all medications you are taking or provide a list: _____

ARE YOU ALLERGIC TO:

Local anesthetics? Yes No

Penicillin? Yes No

General anesthesia? Yes No

Codeine or other narcotics? Yes No

Latex? Yes No

Please list all drug allergies: _____

Are you taking now, have you ever taken or have been given medication for bone disease or osteoporosis, e.g Boniva, Fosamax, Zometa, Novartis, Actonel? Yes No

WOMEN

Is there a possibility of pregnancy? Yes No

Estimated delivery date? ____/____/____

Are you nursing? Yes No

Are you taking birth control pills? Yes No

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.

