# RAMAPO ORAL AND MAXILLOFACIAL SURGERY, P.C.

## HEALTH HISTORY

PATIENT NAME: ___________________________ DATE: ______________

**Answer all questions by checking:** Yes (x) No (x)

**ALL RESPONSES ARE KEPT CONFIDENTIAL**

- Are you in good health Yes ( ) No ( )
- Date of last physical exam___________
- Has there been any changes in your general health in the past year Yes ( ) No ( )

Have you ever had any serious Illness, operations, or hospitalizations Yes ( ) No ( )
Please describe: ____________________________
____________________________________
Medical Doctor: _____________________________
MD's Phone #:_______________________________
Other Medical Doctor: __________ ____________
___________________________________________
Height___________ Weight _________

**DO YOU HAVE OR HAVE YOU HAD:**

- Rheumatic Fever or heart disease Yes ( ) No ( )
- Congenital Heart Disease Yes ( ) No ( )
- Cardiovascular disease (heart attack, heart trouble, murmur, coronary artery disease, angina, high blood pressure, stroke, heart surgery, palpitations, pacemaker, **Please circle**. Yes ( ) No ( )
- Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe cough. **Please circle.** Yes ( ) No ( )
- Seizures, convulsions, epilepsy, fainting, or dizziness. **Please circle.** Yes ( ) No ( )
- Bleeding disorders, anemia, blood transfusion, do you bruise easily?________________ Yes ( ) No ( )
- Liver disease, (Jaundice, Hepatitis) Yes ( ) No ( )
- Kidney disease Yes ( ) No ( )
- Diabetes Yes ( ) No ( )

**Are you allergic to or have you had an adverse reaction to any foods or medications. Please List:**

___________________________________
___________________________________
___________________________________

**Do you have any other disease, condition, or problem not listed above? Please List:**

___________________________________
___________________________________

Is there any past history of Alcohol or Chemical Dependency or emotional disorders Yes ( ) No ( )
Do you smoke or chew tobacco Yes ( ) No ( )
D o you wish to speak to the doctor privately Yes ( ) No ( )

Are you under a doctor's care Yes ( ) No ( )
Sinus or nasal problems Yes ( ) No ( )
Any disease or transplant operation Yes ( ) No ( )

- Thyroid disease (goiter) Yes ( ) No ( )
- Arthritis Yes ( ) No ( )
- Stomach ulcers or colitis Yes ( ) No ( )
- Glaucoma
- Implants placed anywhere in your body (heart valve, pacemaker, hip, knee) Yes ( ) No ( )
- Clicking or popping of jaw joints, pain near the ear, difficulty opening mouth, grinding or clenching of the teeth. Yes ( ) No ( )
- Radiation (x-ray) treatment for cancer: If so, when?_____________________
- Sinus or nasal problems Yes ( ) No ( )
- Any disease, drug or transplant Yes ( ) No ( )

**ARE YOU USING ANY OF THE FOLLOWING:**

- Antibiotics Yes ( ) No ( )
- Anticoagulants (blood thinner) Yes ( ) No ( )
- Aspirin, Aleve, Motrin, Ibuprofen, Plavix, Coumadin, Warfaring, etc. Yes ( ) No ( )
- High Blood pressure medication Yes ( ) No ( )
- Steroid (Cortisone, etc) Yes ( ) No ( )

**Please list ANY AND ALL prescription and over the counter medication taken including herbal or holistic remedies, vitamins or minerals:**

___________________________________
___________________________________
___________________________________
___________________________________
___________________________________

FOR WOMEN ONLY:

- Are you pregnant, or is there a chance you might be pregnant __________ Yes ( ) No ( )
- Are you nursing Yes ( ) No ( )
- Are you using oral contraceptives Yes ( ) No ( )

It is important that you understand that antibiotics (and some medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use alternative forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications are completed. Please consult gynecologist for further guidance.

Signature___________________________________

By signing, I am certifying that I have provided to the best of my knowledge, a truthful medical history.