HEALTH HISTORY Name_____ Date of Birth_____

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 questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit:_____

	Yes	No
Age_____Height_____ Weight_____ Are you in good health?.....	□	□
Have there been any changes in your general health in the past year?	□	□
Are you under the care of a physician?.....Date of last visit_____	□	□
If so, what are you being treated for?_____		
Have you had any illness, operation, or been hospitalized in the past five years?.....	□	□
If so, describe_____		
Do you have any unhealed injuries or inflamed areas, growths or sore spots in or around the mouth?	□	□
If so, describe_____		
Do you have a prosthetic joint/implant?.....	□	□
If so, describe where_____		
Have you had a heart valve replacement or vascular graft?.....	□	□
If so, describe_____		

Do any of the following apply to you?	Yes	No		Yes	No	Notes
Stroke	□	□	Heart Murmur	□	□	
Thyroid Disease	□	□	Damaged heart valves	□	□	
Diabetes	□	□	Mitral valve prolapse	□	□	
Kidney Disease	□	□	High Blood Pressure	□	□	
Arthritis	□	□	Low Blood Pressure	□	□	
Swollen ankles	□	□	Chest Pain / Angina	□	□	
Stomach Ulcers	□	□	Heart Attack	□	□	
Contagious Disease	□	□	Arrhythmia	□	□	
HIV / AIDS	□	□	Cardiac Pacemaker	□	□	
Sexually Transmitted Disease	□	□	Heart Surgery	□	□	
Immune System Issues	□	□	Bronchitis / Cough	□	□	
Delayed Healing	□	□	Asthma	□	□	
Tumor or Growth	□	□	Hay Fever / Sinus Issues	□	□	
Radiation Therapy	□	□	Snoring / Sleep Apnea	□	□	
Chemotherapy	□	□	Breathing or Lung Issue	□	□	
Chronic Fatigue	□	□	Emphysema	□	□	
Drug Abuse history	□	□	Tuberculosis	□	□	
Alcohol Abuse history	□	□	Do you smoke?	□	□	
Eye Disease / Glaucoma	□	□	Do you chew tobacco?	□	□	
Mental Health Problem	□	□	Blood Disease, Anemia	□	□	
Removable Dentures	□	□	Bleeding Tendency	□	□	
Jaw Problems (TMJ)	□	□	Bruise Easily	□	□	
Malignant Hyperthermia	□	□	Hepatitis, Jaundice Liver Disease	□	□	
Gall Bladder Issues	□	□	Anxiety	□	□	
Fainting Spells	□	□	Convulsions / Epilepsy	□	□	
Rheumatic Fever	□	□	Osteoporosis	□	□	
			Contact Lenses	□	□	

MEDICATIONS

	Yes	No	
Are you taking any blood thinners?	□	□	If yes, please list: _____ _____
Are you taking any tranquilizers?	□	□	If Yes, please list: _____ _____
Do you take herbal/natural products?	□	□	If Yes, please describe: _____ _____
Do you use marijuana?	□	□	If Yes, please describe: _____ _____
Do you or have you used opioids?	□	□	If Yes, please describe: _____ _____

Please list any other medications you currently take: _____
_____ _____
_____ _____

ALLERGIES

	Yes	No	If yes, please describe:
Local anesthetics	□	□	_____
Sedation Medications	□	□	_____
General Anesthesia	□	□	_____
Penicillin/Amoxicillin	□	□	_____
Eggs	□	□	_____
Soy	□	□	_____
Latex	□	□	_____

Any other allergies:_____
_____

Is there any condition concerning your health that your doctor should be informed about? Yes □ No □
_____

Do you wish to speak to the doctor privately about anything? Yes □ No □ _____
_____

If you are having general anesthesia or IV sedation today, have you eaten or drank in the last 6 Hours? Yes □ No □

Who is driving you home today? _____

WOMEN ONLY: Are you pregnant or is there a possibility that you are pregnant? Yes □ No □
Are you nursing? Yes □ No □
Are you taking birth control pills? Yes □ No □

Please note that antibiotics (such as amoxicillin) may alter the effectiveness of birth control pills.
Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and 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 staff, responsible for any errors or omissions I have made in completing this form.

Signature of Patient _____ Date_____
(Parent or Guardian if minor)

Reviewed by:_____ Date_____