HEALTH HISTORY Name_____ Birth Date _____

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
Are you in good health? ..... Age____ Height _____ Weight _____	☐	☐
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 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?	☐	☐

Have You Had Or Do You Currently Have ...	Yes	No	Notes
Rheumatic fever?	☐	☐	
Damaged heart valves/ mitral valve prolapse?	☐	☐	
Heart murmur?	☐	☐	
High blood pressure?	☐	☐	
Low blood pressure?	☐	☐	
Chest pain / angina?	☐	☐	
Heart attack(s)?	☐	☐	
Irregular heart beat?	☐	☐	
Cardiac pacemaker?	☐	☐	
Heart Surgery?	☐	☐	
Bronchitis, chronic cough?	☐	☐	
Asthma?	☐	☐	
Hay fever / sinus problems?	☐	☐	
Snoring / sleep apnea?	☐	☐	
Difficulty breathing / other lung trouble?	☐	☐	
Tuberculosis?	☐	☐	
Emphysema?	☐	☐	
Do you smoke?	☐	☐	
Do you use chewing tobacco?	☐	☐	
Blood transfusion?	☐	☐	
Blood disorder, e.g. anemia	☐	☐	
Bruise easily?	☐	☐	
Bleeding tendency / abnormal bleed?	☐	☐	
Hepatitis, jaundice, or liver disease?	☐	☐	
Infectious mononucleosis	☐	☐	
Convulsions / epilepsy?	☐	☐	

Have You Had Or Do You Currently Have ...	Yes	No	Notes
Stroke?	☐	☐	
Thyroid trouble?	☐	☐	
Diabetes?	☐	☐	
Low blood sugar?	☐	☐	
Kidney trouble?	☐	☐	
Are you on dialysis?	☐	☐	
Swollen ankles, arthritis, or joint disease?	☐	☐	
Stomach ulcers?	☐	☐	
Contagious diseases?	☐	☐	
HIV / AIDS?	☐	☐	
Sexually transmitted disease?	☐	☐	
Immune System problems?	☐	☐	
Delay in healing?	☐	☐	
A tumor or growth?	☐	☐	
Radiation therapy / chemotherapy?	☐	☐	
Chronic fatigue / night sweats?	☐	☐	
Are you on a diet?	☐	☐	
A history of drug abuse?	☐	☐	
A history of alcohol abuse?	☐	☐	
Contact lenses?	☐	☐	
Eye disease / glaucoma?	☐	☐	
Mental health problems?	☐	☐	
A removable dental appliance?	☐	☐	
Pain and clicking of the jaws when eating?	☐	☐	
Malignant hyperthermia?	☐	☐	
Gall bladder trouble?	☐	☐	
Fainting spells?	☐	☐	

MEDICATION

Are you now taking…	Yes	No	Notes
Any kind of medication, drugs, or pills?	☐	☐	
Blood thinners (Coumadin, Aspirin, Advil)	☐	☐	
Have you ever taken diet pills?	☐	☐	
Tranquilizers?	☐	☐	
Any natural product, herbal supplement, or homeopathic remedy?	☐	☐	

Please list any other medications you are taking:

_____

_____

_____

_____

ALLERGIES: Are you allergic to or had a reaction to…

	Yes	No	Notes
Local anesthetic (numbing medication)?	☐	☐	
Penicillin?	☐	☐	
Other antibiotics?	☐	☐	
Sulfa drugs?	☐	☐	
Sodium pentothal, Valium, or other tranquilizers?	☐	☐	
Aspirin?	☐	☐	
Codeine or other narcotics?	☐	☐	
Other medications?	☐	☐	
Latex?	☐	☐	
Soy?	☐	☐	
Eggs / Yolk?	☐	☐	
Sulfites?	☐	☐	

Please list any other allergies: _____

_____

WOMEN ONLY

	Yes	No	Notes
Is there a possibility of pregnancy?	☐	☐	
Expected delivery date… ____/____/____			
Are you nursing?	☐	☐	
Are you taking birth control pills?	☐	☐	

Women Note: ***Antiobiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.***

All Patients: Is there any condition concerning your health that the doctor should be told about? ……

☐Yes ☐No (if so, describe) _____

_____

_____

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

Is there a family history of:	Yes	No
Cancer ?	☐	☐
Diabetes ?	☐	☐
Heart Disease ?	☐	☐
Anesthetic problems ?	☐	☐

IF YOU ARE HAVING SURGERY TODAY, have you had anything to eat or drink in the last 6 hours? ☐Yes ☐No

Who is driving you home? _____

_____

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 staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient: _____ Reviewed by: _____Date_____
(Parent or Guardian if minor)