Health History

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.

Patients Name:_____

Reason for today's office visit:_____

		Yes	No
1.	Are you in good health? _____Yes _____No Height _____ Weight_____		
2.	Have there been any changes in your general health in the past year?	☐	☐
3.	Are you under the care of a physician? _____Yes _____No 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?	☐	☐
5.	Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?_____ If so describe where _____		
6.	Have you had a prosthetic joint/implant?_____ If so, describe where _____		
7.	Have you had a heart valve replacement, vascular graft or stent?	☐	☐

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE....	Yes	No	NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE....	Yes	No	NOTES
8	Rheumatic fever?				34	Stroke?			
9	Damaged heart valves / mitral valve prolapse?				35	Thyroid trouble?			
10	Heart murmur?				36	Diabetes?			
11	High blood pressure?				37	Low blood sugar?			
12	Low blood pressure?				38	Kidney trouble?			
13	Chest pain, angina?				39	Are you on dialysis?			
14	Heart attack(s)?				40	Hiatal Hernia / Acid Reflux			
15	Irregular heart beat?				41	Stomach ulcers?			
16	Cardiac pacemaker?				42	Contagious diseases?			
17	Heart surgery?				43	V.D. / HIV / AIDS			
18	Bronchitis, chronic cough?				44	Problems with the immune system?			
19	Asthma?				45	Delay in healing?			
20	Hay fever / sinus problems?				46	A tumor or growth?			
21	Tuberculosis?				47	X-Ray treatment / chemotherapy?			
22	Emphysema?				48	Chronic fatique / night sweats?			
23	Difficult breathing / other lung trouble?				49	Are you on a diet?			
24	Do you smoke?				50	A history of drug abuse?			
25	Blood transfusion?				51	A history of alcohol abuse?			
26	Blood disorder such as anemia?				52	Contact lenses?			
27	Sickle Cell Disease / Trait				53	Eye disease / glaucoma?			
28	Bleeding tendency (abnormal bleed)?				54	Sleep Apnea			
29	Jaundice, hepatitis or liver disease?				55	A removable dental appliance?			
30	Frequent Nose Bleeds				56	Pain & clicking of jaws when eating?			
31	Motion Sickness				57	Malignant hyperthemia?			
32	Fainting spells?				59	**IF YOU ARE HAVING SURGERY TODAY?** have you had anything to eat or drink in the last 8 hours?			
33	Convulsions, epilepsy?				60	Who is driving you home?			

MEDICATION

List all prescription and non-prescription medications and supplements (herbal or homeopathic.)

ALLERGIES

List all medication and environmental allergies including latex

WOMEN

	YES	NO			YES	NO	
61. Is there a possibility of pregnancy?				63. Are you nursing?			
62. Estimated delivery date? ___/ ___/ ___				64. Are you taking birth control pills?			

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.

List any other health conditions not already noted.

Physicians	Name	Phone #
Medical Doctor		
Cardiologist		

Previous Surgeries	Date	Anesthesia - type	Complication

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

Signature of patient: X_____ Reviewed by: X_____ Date: X_____
(Parent or Guardian if minor)

Have there been any changes in your health history since your previous visit? Yes ____ No ____

Signature of patient: X_____ Reviewed by: X_____ Date: X_____
(Parent or Guardian if minor)