ORAL SURGERY HEALTH HISTORY

I. General Information

To our Patients: Although oral surgeons treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you are taking could have an important relationship with the care that you are receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential. ***Please check yes or no for all the following questions***

Name: ____ Date:__________
Reason for today's office visit: ____

___Yes ___No Are you in good health? Height _________ Weight _________
___Yes ___No Have there been any changes in your general health in the past year?________________________
___Yes ___No Are you under the care of a physician? Date of last visit______________
If YES, for what are you being treated?____
___Yes ___No Have you had any illness, operation, or been hospitalized in the past five years?
If YES, for please list?____
___Yes ___No Have you, or a family member, had any unusual or serious reactions to general anesthetic?
___Yes ___No Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment?
___Yes ___No Have you had any trouble with previous dental treatment?
___Yes ___No Do you wear contact lenses?
___Yes ___No Do you have a removable dental appliance?

Have you had or currently have	Yes	No	Notes
Cardiovascular problems			
Heart Disease (family history)			
Heart Murmur/Artificial Valves			
Heart Attack / Angina			
Mitral Valve Prolapse			
Bleeding Tendency			
Blood Transfusion			
Rheumatic Fever/Heart Diseases			
High Blood Pressure			
Low Blood Pressure			
Cardiac Pacemaker			
Irregular Heart Beat			
Heart Surgery			
Swollen Ankles			
Leukemia/Anemia			
Circulatory Problems			
Congenital Heart Disease/Lesions			
Cardiac Stent			
Damaged/Artificial Heart Valves			
Coronary Insufficiency			
Coronary Occlusion			
Chest Pain			
Blood Clots			
Peripheral Vascular Disease			
Respiratory / Lungs			
Asthma			
Bronchitis			
Chronic Cough			
Difficulty Breathing			
Emphysema/Shortness of Breath			
Pneumonia			
Tuberculosis			
Sinus Trouble			
Hay Fever/Allergies			

Have you had or currently have	Yes	No	Notes
Neurological			
Fainting Spells			
Epilepsy/Convulsions/Seizures			
Stroke/Transient Ischemic Attack			
Mental Health Problems			
Kidney / Liver Diseases			
Kidney Trouble			
Jaundice, Hepatitis, Liver Disease			
Dialysis			
Musculoskeletal			
Arthritis/Rheumatism			
Prosthetic Knee/Hip etc.			
Muscle Weakness/Paralysis			
TMJ-Pain & Clicking of Jaws			
Numbness/Tingling			
Other			
Diabetes			
Low Blood Sugar			
AIDS/HIV			
Sexually Transmitted Diseases			
Cancer/Cancer Treatment			
Tumor or Growth			
Chemotherapy or Radiation			
Swollen Glands in Neck			
Thyroid Trouble			
Hiatal Hernia			
Acid Reflux			
Stomach Trouble/Ulcers/Nausea			
Glaucoma/Eye Disease			
Frequent/Recurring Sores in Mouth			
History of Drug/Alcohol Abuse			
Problems with Immune System			
Frequently Tired			
Weight Loss or Gain			

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II. Allergy Information

	Yes	No	Notes
Local Anesthetic			
Penicillin/Amoxicillin/Sulfa			
Other Antibiotics			
Sodium Pentothal/ Valium			
Other Tranquilizers			
Aspirin			
Iodine			
Barbituates/Sedatives/SleepingPills			

	Yes	No	Notes
Codeine or other Narcotics			
Other Medications			
(Please List)			
Latex Allergy			
Allergies other than Drug Allergies			
Food Allergies (soy,eggs,sulfites)			
Other known Allergies			
(Please List)			

III. Medication Information

Are you now taking:	Yes	No	Notes
Birth Control Pills			
Anticoagulant (Blood thinners, Coumadin, Plavix, Vitamin E, Fish Oil, Pradaxa, Ginko Biloba, Aggrenox)			
Tranquilizers, sleeping pills			
Anti-depressants, Narcotics			

Have you ever taken:	Yes	No	Notes
Diet Pills (Phen-fen)			
Osteoporosis Medication or any medication that alters bone density e.i. biophosphates(Boniva, Fosamax, Reclast)			
Cocaine, Heroine, Methamphetamine or other controlled substances			

List all other medications, non-prescription medications, herbal medicines, and vitamins:

Women Only: Are you pregnant or think you may be? ____Yes ____No
Are you nursing? ____Yes ____No

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

___Yes ___No Is there any other disease, condition, or problem concerning your health that the Doctor should be made aware of?
If YES, please explain:

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 errors or omissions that I have made in the completion of this form.

Patient's (or Legal Guardian's) Signature____ Date________________

I further certify that I have not had anything to eat or drink in the last 6 hours ___Yes ___No
I understand that to do otherwise may be life threatening.

Patient's (Legal Guardian's) Signature____ Date_______________