Health History

Liberty
Oral & Facial Surgery

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.

Reasons for today's office visit: _____

Occupation: _____

	Yes	No
Are you in good health? .... 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, for what are you being treated? _____		
Have you had any illnesses, operations or been hospitalized in the past five years?	❑	❑
If yes, please explain: _____		

	Yes	No
Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
If so describe where _____		
Do you have a prosthetic joint/implant?	❑	❑
If so describe where _____		
Have you had a heart valve replacement or vascular graft?	❑	❑

EMERGENCY CONTACT: Name: _____ Tel. # H: _____ Wk: _____ Cell: _____

Advanced Directive: ❑ Yes ❑ No (If yes, please refer to your Patient Rights and Responsibilities Brochure.)

Special considerations due to cultural or religious beliefs: ❑ Yes ❑ No Specify: _____

Language: ❑ English ❑ Spanish ❑ Russian ❑ Other: _____ ❑ Translator Needed

Learning variables: ❑ None ❑ Hearing ❑ Vision ❑ Cognitive Impairment ❑ Illiterate ❑ Pain ❑ Anxiety

Are you ready to learn about your care? ❑ Yes ❑ No Learning preference: ❑ Written ❑ Verbal ❑ Demonstration

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	YES	NO
Rheumatic fever?		
Damaged heart valves/ mitral valve prolapse?		
Heart murmur?		
High blood pressure?		
Low blood pressure?		
Chest pain / angina?		
Heart attack?		
Irregular heart beat?		
Cardiac pacemaker?		
Heart surgery?		
Bronchitis / chronic cough?		
Asthma?		
Hay fever / sinus problems?		
Tuberculosis?		
Emphysema?		
Difficulty breathing / other lung trouble?		
Do you smoke?		
___ Tobacco ___ Marijuana ___ Other		
Blood transfusion?		
Blood disorder such as anemia?		
Bruise easily?		
Bleeding tendency / abnormal bleeding?		
Jaundice / hepatitis / liver disease?		
Mononucleosis?		

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	YES	NO
Gallbladder trouble?		
Osteoporosis?		
Fainting spells?		
Convulsions / epilepsy?		
Stroke?		
Thyroid trouble?		
Diabetes?		
Low blood sugar?		
Kidney trouble?		
Are you on dialysis?		
Swollen ankles / arthritis / joint disease?		
Stomach ulcers?		
Contagious diseases?		
Sexually transmitted diseases?		
Problems with the immune system?		
Delay in healing?Cancer?		
A tumor or growth?		
X-ray treatment / chemotherapy?		
Chronic fatigue / night sweats?		
A history of drug abuse?		
A history of alcohol abuse?		
Eye disease / glaucoma?		
Sleep apnea?		

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	YES	NO
Mental health problems?		
Malignant Hyperthermia?		
Are you on a special diet?		
Contact lenses?		
A removable dental appliance?		
Pain & clicking of jaws when eating?		

IS THERE A FAMILY HISTORY OF:	YES	NO
Cancer?		
Diabetes?		
Heart disease?		
Anesthetic problems?		
Malignant Hyperthemia?		

WOMEN:	YES	NO
Is there a possibility of pregnancy?		
Estimated delivery date? __/__/__		
Are you nursing?		
Are you taking birth control pills?		
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.		
Any other condition concerning your health the doctor should know? Please explain:		

I certify that I have read and I understand the questions above. I acknowledge that my questions, 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: _____ Reviewed by: (Staff Only) _____ Date: _____
(if under 18 parent/ legal guardian)

Relationship To Patient: Please Circle One: Parent/Guardian Self Other: _____

Patient Last: _____ Patient First: _____ Patient Middle Initial: _____

Patient Medication Summary

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ALLERGIES: ❑ No Known ❑ Penicillin ❑ Sulfa ❑ Latex ❑ Aspirin ❑ Food ❑ Local Anesthetics

❑ Codeine/Other Narcotics _____ ❑ Other: _____

❑ Reaction: _____

Previous reactions to anesthesia ❑ Yes ❑ No Reaction: _____

PREFERRED PHARMACY: _____ LOCATION: _____ PHONE NUMBER: _____

DATE	Past Surgeries

DATE	Medications, Prescriptions, Over the Counter, Herbal & Vitamin Supplements

❑ See Medication List Attached

FOR OFFICE USE ONLY	
DATE	PreOp Orders
	❑ ASA 1 2 3 4 5
	❑ Start IV and give D5 0.45 NS or LR at TKO
	❑ Ancef 1gm IV ❑ Clindamycin 600mg IV
	❑ Albuterol Inhaler ❑ Epi Inhaler 2 puffs Pre-Op
	❑ Zofran 4mg IV ❑ Phenergan 12.5mg IV
	❑ Glucose Check ❑ INR Check
	❑ Post Op RX:

_____ _____

Doctor Signature Date

_____ _____

Doctor Signature (If orders update) Date

FOR OFFICE USE ONLY	
DATE	Medications Administered/Reconciliation
	❑ Propofol (mg)
	❑ Versed (mg) ❑ Fentanyl (mcg)
	❑ Decadron (mg) ❑ Ketamine (mg)
	❑ 2% Lidocaine 1:100,000 epi (carps)
	❑ 0.5% Marcaine 1:200,000 epi (carps)
	❑ 4% Articaine 1:200,000 epi (carps)
	❑ 3% Carbocaine (carps)
	❑ Clindamycin (mg) ❑ Ancef (mg)
	❑ Zofran (mg)
	❑ Phenergan (mg)
	❑ Other
	❑ **Continue all Physician prescribed medications unless directed otherwise.**
	❑ Changes: _____ _____

Patient Last: _____

Patient First: _____ Signature: _____
(Please Print)

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Veradale, WA 99037
(509) 922-2273

PATIENT INFORMATION (Please Print)

Title: _____ First Name: _____ MI: _____ Last Name: _____

Birthdate: _____ Soc. Sec.: _____ Gender: ☐ Male ☐ Female

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext: _____

Mobile: _____ Fax: _____ Email: _____

Employer: _____ Phone: _____ Occupation: _____

Referred By: _____ General Dentist: _____

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: _____ First Name: _____ MI: _____ Last Name: _____

Relationship to Patient: ☐ patient ☐ spouse ☐ child ☐ other - please specify _____ Soc. Sec.: _____

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext: _____

Mobile: _____ Fax: _____ Email: _____

Employer: _____ Phone: _____ Occupation: _____

DENTAL/MEDICAL INSURANCE INFORMATION

Primary Insurance

Ins. Co. _____

Group #: _____ Phone: _____

Employer: _____

Employee (if other than patient)

Name: _____

Birthdate: _____ Soc. Sec: _____

Subscriber #: _____ Sex: ☐ Male ☐ Female

Secondary Insurance

Ins. Co. _____

Group #: _____ Phone: _____

Employer: _____

Employee (if other than patient)

Name: _____

Birthdate: _____ Soc. Sec: _____

Subscriber #: _____ Sex ☐ Male ☐ Female

Medical/Primary Care Physician: _____

Phone: _____

Emergency Contact: _____

Relationship: _____

Emergency Contact Phone: _____

_____ _____

Signature (parent or guardian if patient is a minor) Date

_____ _____

Signature of authorized representative of Liberty Oral And Facial Surgery Date