# 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 your 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 Check One: ❑ Parent/Guardian ❑ Self ❑ Other: _____

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

# Patient Medication Summary

Liberty
Oral & Facial Surgery

**ALLERGIES:** ❑ No Known allergies
List allergies

| | REACTION: |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

Previous reaction to anesthesia ❑ Yes ❑ No If yes; reaction: _____
Previous reaction to local anesthetics ❑ Yes ❑ No If yes; reaction: _____

PREFERRED PHARMACY: _____ LOCATION: _____ PHONE NUMBER: _____

Medications: *Include prescription, over the counter, herbal and vitamin supplements.*

❑ See Medication List Attached

| Name | Dose | Frequency | Reason for taking |
|---|---|---|---|
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| DATE | Past Surgeries |
|---|---|
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| DATE | PreOp Orders |
|---|---|
| | ❑ ASA 1 2 3 4 5 |
| | ❑ Start IV ❑ Pregnancy Test |
| | ❑ Cefazolin 1gm IV ❑ Clindamycin 600mg IV |
| | ❑ Albuterol Inhaler 2 puffs Pre-Op |
| | ❑ Epi Inhaler 2 puffs Pre-Op |
| | ❑ Ondansetron 4mg IV |
| | ❑ Glucose Check ❑ INR Check |
| | ❑ Post Op RX: |
| | ❑ Other: |

_____ _____
Doctor Signature Date

_____ _____
Doctor Signature (If orders update) Date

| | |
|---|---|
| | ❑ **Continue all Physician prescribed medications unless directed otherwise.** |
| | ❑ Changes: _____ |

Patient Last: _____

Patient First: _____ Signature: _____
(Please Print)