

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 your records only and will be considered confidential.

Reasons for today's office visit: _____

Occupation: _____

Are you in good health? Height _____ Weight _____	Yes No	Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?	Yes No
Have there been any changes in your general health in the past year?	<input type="checkbox"/> <input type="checkbox"/>	If so describe where _____	<input type="checkbox"/> <input type="checkbox"/>
Are you under the care of a physician?	<input type="checkbox"/> <input type="checkbox"/>	Do you have a prosthetic joint/implant?	<input type="checkbox"/> <input type="checkbox"/>
Date of last visit: _____		If so describe where _____	
If so, for what are you being treated? _____		Have you had a heart valve replacement or vascular graft?	<input type="checkbox"/> <input type="checkbox"/>
Have you had any illnesses, operations or been hospitalized in the past five years?	<input type="checkbox"/> <input type="checkbox"/>		
If yes, please explain: _____			

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?		
GLP-1 / Weight loss medication?		
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 Hyperthermia?		

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: _____

