HEALTH HISTORY FOR ORAL SURGERY

PATIENT'S NAME: ______________________________________ **DOB:** _____________________________

PANO TAKEN: _____________________

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications 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.

	Yes	No
1. ***Height***__________________ ***Weight***__________________ Are you in good health?	☐	☐
2. Have there been any changes in your general health in the past year?	☐	☐
3. Are you under the care of a physician?. . . . . ***Date of last visit***__________________	☐	☐
If so, what are you being treated for? ____		
4. Have you had any illness, operation or been hospitalized in the past five years?	☐	☐
5. Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	☐	☐
If so, describe where ____		
6. Do you have a prosthetic joint / implant / heart valve replacement . . . . ***If so, where*** ____________ ***when*** ___________	☐	☐
7. Have you ever had general anesthesia	☐	☐
8. Have you, or a family member, had any unusual or serious reactions to general anesthesia?	☐	☐

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:	YES	NO
9. Asthma		
10. Difficulty breathing		
11. Other lung problems / cough		
12. A Pacemaker / Heart valve replaced		
13. Heart problems		
14. Chest pain		
15. Irregular heart beat		
16. Heart surgery		
17. Stroke		
18. Trouble climbing two flights of stairs		
19. High or Low Blood Pressure		
20. Sleep Apnea / Use CPAP		
21. Bleeding Disorder		
22. Bruise / Bleed easily		
23. Hepatitis / Liver Disease		
24. Faint easily		
25. Seizures		
26. Thyroid Trouble		
27. Diabetes		
28. Kidney problems		
29. Dialysis		

HAVE YOU HAD OR DO YOU CURRENTLY HAVE	YES	NO
30. Dementia and/or Alzheimer's		
31. High Cholesterol		
32. Arthritis		
33. Osteoporosis		
34. Prosthetic joint		
35. Stomach ulcers / reflux		
36. Immune system problems		
37. Slow healing		
38. Tumor or growth		
39. Cancer / Radiation/ Chemo		
40. Eye disease / glaucoma		
41. Mental health problems / anxiety/depression		
42. Developmental Delay		
43. Removable dental appliance		
44. Pain or clicking of jaws		
45. Do you use Tobacco		
46. Do you use Alcohol		
47. History of controlled substances		
48. HIV / AIDS		
49. Any other condition not listed		
50. Other condition:____________________		

WOMEN ONLY:

Is there a possibility of pregnancy? . . . . Yes ☐ No ☐

Expected delivery date? ______________________________

Are you nursing? . . . . Yes ☐ No ☐

Are you taking birth control pills? . . . . Yes ☐ No ☐

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

MEDICATION AND ALLERGY INFORMATION

ARE YOU NOW OR HAVE YOU EVER TAKEN:	YES	NO
51. Any kind of medication, drug or pills		
52. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba, Aggrenox, Pradaxa, Fish oil)		
53. Have you ever taken diet pills		
54. Any natural product, herbal supplement or homeopathic remedy		
55. Are you taking, or have you ever taken, bone density medications, or bisphosphonates such as Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Xgeva, Prolia, or Reclast in the past 12 years		

56. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

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ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO
57. Local anesthetic (numbing meds.)		
58. Penicillin		
59. Other antibiotics		
60. Sulfa drugs.		
61. Sodium pentothal / Valium/ other tranquilizers		
62. Aspirin		
63. Amoxicillin		
64. Codeine or other narcotics		
65. Other medications		
66. Latex		
67. Soy		
68. Eggs / yolk		
69. Sulfites		
70. Do you have any known allergies		

71. Please list any allergies other than drug allergies:

Is there a family history of:

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Anesthesia Problems

Is there any condition concerning your health that the Doctor should be told about? ☐ YES ☐ NO - If yes, describe:

____

____

If you are having surgery ***TODAY***, have you had anything to eat or drink in the last 8 (eight) hours? ☐ Yes ☐ No

Who is driving you home? ____________________________

MEDICATION LIST

Please list any medications you are currently taking. Or, if you have a list, please give it to us and we will make a copy for our records.

MEDICATION	DOSAGE	FREQUENCY

PHARMACY INFORMATION

Name of Pharmacy: ________________________________

Location: ____

NAME OF PRIMARY PHYSICIAN

____

I certify that I have read and I understand the questions above. I will not hold The Dentists' Office, my doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

X____ Date: ______________________

Signature of patient (Parent or Guardian if Minor)