

**HEALTH HISTORY:**

**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.

Reason for today's office visit? \_\_\_\_\_

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>Yes</b>               | <b>No</b>                |
| 1. <b>Height</b> _____ <b>Weight</b> _____ Are you in good health? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health in the past year? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you under the care of a physician? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Date of last visit</b> _____  |                          |                          |
| <b>If so, for what are you being treated?</b> _____  |                          |                          |
| 4. Have you had any illness, operation or been hospitalized in the past five years? .....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If so, describe</b> _____   |                          |                          |
| 5. Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If so, describe where</b> _____   |                          |                          |
| 6. Do you have a prosthetic joint / implant? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If so, describe where</b> _____   |                          |                          |
| 7. Have you had a heart valve replacement or vascular graft? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had general anesthesia? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you, or a family member, had any unusual or serious reactions to general anesthesia? .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke? If so, number of packs a day _____			
30. Do you use chewing tobacco?			
31. Blood transfusion?			
32. Blood disorder such as anemia?			
33. Bruise easily?			
34. Bleeding tendency / abnormal bleed?			
35. Hepatitis, jaundice, or liver disease?			
36. Infectious mononucleosis?			
37. Gallbladder trouble?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Fainting spells?			
39. Convulsions / epilepsy?			
40. Stroke?			
41. Thyroid trouble?			
42. Diabetes?			
43. Low blood sugar?			
44. Kidney trouble?			
45. High cholesterol?			
46. Are you on dialysis?			
47. Swollen ankles / arthritis / joint disease?			
48. Osteoporosis / osteopenia?			
49. Osteonecrosis?			
50. Acid reflux?			
51. Stomach / GI troubles / ulcers / IBS / colitis?			
52. Contagious diseases?			
53. Sexually transmitted diseases?			
54. Problems with immune system? Possibly from medication / surgery, etc.			
55. Delay in healing?			
56. A tumor or growth?			
57. Cancer / radiation therapy / chemotherapy?			
58. Chronic fatigue / night sweats?			
59. Are you on a diet?			
60. A history of alcohol abuse?			
61. A history of drug abuse?			
62. Contact lenses?			
63. Eye disease / glaucoma?			
64. Mental health problems / anxiety / depression?			
65. A removable dental appliance?			
66. Pain or clicking of jaws when eating?			

**WOMEN ONLY: (QUESTIONS 67-70)**

- |  |                              |                             |   |                              |                             |
|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| 67. Is there a possibility of pregnancy? ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 69. Are you nursing? .....                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 68. Expected delivery date? _____              |                              |                             | 70. Are you taking birth control pills? ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> 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.