

HEALTH HISTORY QUESTIONNAIRE

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 truthfully and accurately. All answers are for our records only and are confidential.

Name (Last, First, M.I.): M F **DOB:** _____

GENERAL HEALTH

Has there been any change in your general health within the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
When was your last physical examination?		
Are you under the care of a physician?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For what condition?	What is your primary physician's name?	
Have you had any serious illness or operation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What was the illness or operation?		
Have you had any serious trouble associated with any previous dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you had or do you currently have...	YES	NO	NOTES
Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	
Damaged heart valves/ mitral valve prolapse?	<input type="checkbox"/>	<input type="checkbox"/>	
Heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain/ angina?	<input type="checkbox"/>	<input type="checkbox"/>	
Heart attack(s)?	<input type="checkbox"/>	<input type="checkbox"/>	
Irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	
Heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis, chronic cough?	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	
Hay fever/ sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Snoring / sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult breathing/ other lung trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood disorder such as anemia?	<input type="checkbox"/>	<input type="checkbox"/>	
Bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding tendency/ abnormal bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis, jaundice, or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS or HIV?	<input type="checkbox"/>	<input type="checkbox"/>	

Have you had or do you currently have...	YES	NO	NOTES
Fainting spells?	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsions/ epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke?	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
Low blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you on dialysis?	<input type="checkbox"/>	<input type="checkbox"/>	
Swollen ankles, arthritis or joint disease?	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis/ Osteopenia?	<input type="checkbox"/>	<input type="checkbox"/>	
Osteonecrosis?	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	
Contagious diseases?	<input type="checkbox"/>	<input type="checkbox"/>	
Sexually transmitted diseases?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you immunosuppressed? Possibly from transplant surgery, etc.	<input type="checkbox"/>	<input type="checkbox"/>	
Delay in healing?	<input type="checkbox"/>	<input type="checkbox"/>	
A growth or tumor	<input type="checkbox"/>	<input type="checkbox"/>	
Radiation therapy/ chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic fatigue/ night sweats?	<input type="checkbox"/>	<input type="checkbox"/>	
A history of drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>	
A history of alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>	
Contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
Mental health problems?	<input type="checkbox"/>	<input type="checkbox"/>	
A removable dental appliance?	<input type="checkbox"/>	<input type="checkbox"/>	
Pain and clicking of jaws when eating?	<input type="checkbox"/>	<input type="checkbox"/>	
Malignant hyperthermia?	<input type="checkbox"/>	<input type="checkbox"/>	

Please turn to next page

MEDICATION - Are you taking or have you taken...

	YES	NO	NOTES
Antibiotics or sulfa drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Antihistamines?	<input type="checkbox"/>	<input type="checkbox"/>	
Insulin, Tolbutamide (Orinase) or similar drug?	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone (steroids)?	<input type="checkbox"/>	<input type="checkbox"/>	
Nitroglycerine?	<input type="checkbox"/>	<input type="checkbox"/>	
Medication for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba)?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever taken diet pills?	<input type="checkbox"/>	<input type="checkbox"/>	
Any natural products, herbal supplement or homeopathic remedy?	<input type="checkbox"/>	<input type="checkbox"/>	
Any bone density medications/ Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever taken tranquilizers, sleeping pills, antidepressants, and/ or narcotics on a regular basis? If so, please list:	<input type="checkbox"/>	<input type="checkbox"/>	
Please list any medications you are currently taking:			
Please explain any disease, condition, or problem not listed above that you think we should know about:			

Allergies - Are you allergic to, or had a reaction to...

	YES	NO	NOTES
Local anesthetic (numbing med)?	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillin?	<input type="checkbox"/>	<input type="checkbox"/>	
Other antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfa Drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Sodium pentothal, Valium, or other tranquilizers?	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine or other narcotics?	<input type="checkbox"/>	<input type="checkbox"/>	
Other medications?	<input type="checkbox"/>	<input type="checkbox"/>	
Latex?	<input type="checkbox"/>	<input type="checkbox"/>	
Soy?	<input type="checkbox"/>	<input type="checkbox"/>	
Eggs/ yolk?	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfites?	<input type="checkbox"/>	<input type="checkbox"/>	
Please list any allergies other than drug allergies:			
WOMEN ONLY:			
Date of last menstruation:			
	YES	NO	NOTES
Is there a possibility of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any problems associated with your menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>	
Doctors notes:			

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form. **I authorize** my surgeon and his/ her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Signature or patient (or parent if minor)

X

Date: X

Doctors

Signature: X

Witness

Initials: X