Oral Surgical Associates

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Health History

Patient's Name _____ Date of Birth _____ Height _____ Weight _____

Answer all the questions by circling YES (Y) or NO (N)

All responses are kept confidential

1. Has there been any change in your general health the past year.....Y N
2. Date of Last Physical Exam:_____
3. Are you under a physician's care for any particular reason.....Y N
4. Have you ever had any serious illnesses, operations or hospitalizations?.....Y N
   Please describe:_____
5. Do you have or have you ever had:
   a. Rheumatic Fever or Rheumatic Heart Disease.....Y N
   b. Congenital Heart Disease.....Y N
   c. Cardiovascular Disease (Heart Disease, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker).....Y N
   d. Lung Disease (Asthma, Emphysema, COPD, Chronic cough, Bronchitis, Pneumonia, TB, Shortness of Breath, Chest Pain, Severe Coughing)..... Y N
   e. HIV or AIDS.....Y N
   f. Herpes.....Y N
   g. Seizures, Convulsions, Epilepsy, Fainting or Dizziness.....Y N
   h. Bleeding Disorder or Anemia .....Y N
   i. Liver Disease (Jaundice, Hepatitis).....Y N
   j. Kidney Disease.....Y N
   k. Diabetes.....Y N
      If yes, TYPE 1 or TYPE 2
   l. Thyroid Disease.....Y N
   m. Arthritis.....Y N
   n. Stomach Ulcers or Colitis.....Y N
   o. Glaucoma.....Y N
   p. Osteoporosis.....Y N
   q. Artificial Joints .....Y N
      If yes please list_____
   r. Heart Valve Replacement or Pacemaker.....Y N
   s. Radiation Treatment for Cancer.....Y N
   t. Have you ever had a bone density scan.....Y N
   u. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grinding or clenching teeth.....Y N
   v. Any disease, drug or transplant operation that has depressed your immune system.....Y N
6. Are you using any of the following;
   a. Steroids (Cortisone, Prednisone).....Y N
   b. Are you taking or have you ever taken **BISPHOSPHONATES** for osteoporosis, multiple myeloma or cancer which include; Actonel, Boniva, Didronel, Evista, Fosamax, Reclast, Skelid, Aredia, Zometa, Prolia.....Y N
   c. Have you ever been advised not to take a medication.....Y N
      If yes which medication_____
   d. Please list any and all medications you are currently taking, including vitamins and supplements:

      _____
      _____
      _____
      _____
      _____
      _____
      _____
      _____

CONTINUE ON BACK

7. Are you allergic to or have you had an adverse reaction to:
    a. Local Anesthesia (Novocain, Lidocaine, Marcaine, ect)…….Y N
    b. Penicillin or other antibiotics……..Y N
    _____
    c. Codeine or Other Painkillers……Y N
    _____
    d. Latex……Y N
    e. Aspirin……Y N
    f. Food Products……..Y N
    _____
    g. Other Allergies or Reactions Please List:
    _____
    _____
    _____
8. Psychiatric Treatment……Y N
9. Do you smoke or chew tobacco……Y N
    a. Amount per day_____
10. Do you drink alcohol……..Y N
    a. Drinks per week_____
11. Have you had any serious problems associated with any previous dental treatment……..Y N
12. Have you ever had any issues associated with IV anesthesia……Y N
13. Do you have any other disease, condition or problem not listed above, that you think the doctor should be aware of……...Y N
    a. If yes please explain:_____
14. Do you wish to talk to the doctor privately about anything……..Y N
15. **FOR WOMEN ONLY**
    a. Are you pregnant, or is there any chance you may be pregnant……..Y N
    b. Are you nursing……..Y N

I understand the importance of a truthful and complete health history to assist the doctor in providing the best care possible. I understand I will have the opportunity to discuss my health history with the doctor.

_____

Signature of patient or legal guardian if patient is under 18 Date