HEALTH HISTORY

SOUTHERN WEST VIRGINIA ORAL MAXILLOFACIAL SURGEONS, LTD

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Height: _____ Weight: _____ Age: _____

Physician Name: _____ Dentist Name: _____ Orthodontist Name:_____

Reason for Visit: _____ How were you referred to us? _____

Answer all questions by circling Yes (Y) or No (N). All responses are kept completely confidential.

1. DO YOU HAVE OR HAVE YOU EVER HAD:

A. Rheumatic Fever or Rheumatic Heart Disease? Y N

B. Congential Heart Disease? Y N

C. Cardiovascular Disease (Check all that apply)

□ Heart Attack □ Heart Trouble □ Heart Murmur □ Angina

□ Coronary Artery Disease □ High Blood Pressure □ Stroke

D. Lung Disease (Check all that apply) Y N

□ Asthma □ Emphysema □ COPD □ Chronic Cough

□ Pneumonia □ Tuberculosis □ Shortness of Breath □ Chest Pain

□ Severe Coughing □ Sleep Apnea □ Bronchitis

E. Neurological Disorder (Check all that apply) Y N

□ Seizures □ Convulsions □ Epilepsy □ Fainting □ Dizziness

F. Hematology Disorder (Check all that apply) Y N

□ Anemia □ Bleeding Tendency □ Blood Transfusion

□ Bruise Easily □ Bleeding Disorder □ Anticoagulant Therapy

G. Liver Disease Y N

□ Cirrhosis □ Jaundice □ Hepatitis Y N

H. Kidney Disease Y N

I. Diabetes? □ Type I or □ Type II Y N

J. Thyroid Disease (Goiter) Y N

K. Arthritis Y N

L. Stomach Ulcers or Colitis Y N

M. Glaucoma Y N

N. Osteoporosis? Taking Meds?_____ Y N

O. Implants placed anywhere in your body? Y N

□ Heart Valve □ Pacemaker □ Hip □ Knee □ Dental

P. Radiation (X-ray) treatment for cancer? Y N

Q. Any problems with the following? Y N

□ Clicking or popping of jaw joint □ pain near ear

□ difficulty opening mouth □ grind or clench teeth

R. Sinus or Nasal Problems? Y N

S. Any disease, drug or transplant operation that has depressed your immune system? Y N

_____

_____

T. Infections or Infectious Disease? Y N

□ MRSA"Mersa" □ Colitis from Antibiotic Use

5. Are you using Methadone or Suboxone Treatment? Y N

6. Are you taking or *have you ever taken* Bisphosphatenates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia, Xgevin)? Y N

7. Have you ever had a bone density scan? Y N

8. Do you smoke or chew Tobacco? Y N

Chewing or Smoking? How much per day? _____

9. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the anesthesia care we provide you? Y N

10. Have you had any serious problems associated with any previous dental treatment? Y N

_____

11. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N

12. FOR WOMEN ONLY

A. Are you pregnant, or <u>Is there any chance</u> you might be pregnant? Y N

B. Are you nursing? Y N

14. Do you wish to talk to the doctor privately about anything? Y N

13. Do you have any other disease, condition or problem not listed above that you think the doctor should know? Y N

_____

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_____

I understand the importance of a truthful Health History to assist my oral surgeon in providing the best care possible. I have had the opportunity to discuss my Health History with my surgeon.

_____ _____ _____

Date **Signature of Person Completing Health History** **Reviewing Doctor's Initials**

SURGERIES / MEDICATIONS / ALLERGIES

Patient Name: _____ DOB: _____ Cell Phone: _____

Date of last physical exam? _____

Have you ever had any serious illnesses, operations or hospitalizations? If so, explain. Y or No

_____

_____

_____

Please list any and all medications taken. Including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals. If you have a list you wish for us to just copy, just write "See Attached List" and give list to front desk to make copy.

_____

_____

_____

ARE YOU ALLERGIC TO OR HAVE HAD AN ADVERSE REACTION (Hives, Rash, Itching) TO:

A. Local Anesthesia (Novacaine, etc.) ?	Y	N
B. Antibiotics (Penicillin, Erythromycin, etc.)?	Y	N
C. Sedatives, Barbiturates?	Y	N
D. Aspirin or Ibuprofen?	Y	N
E. Codeine or other pain medications?	Y	N
F. Latex or Rubber products?	Y	N
G. Metal of any kind?	Y	N
H. Chemicals or jewelry (rash or sensitivity)	Y	N
I. Food products?	Y	N
J. Have you ever been advised not to take a medication?	Y	N

_____

_____

K. Please list any other allergies and/or reactions.

_____

_____

_____