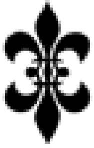

SOUTHEAST ORAL *and* MAXILLOFACIAL SURGERY

# HEALTH HISTORY

Welcome to our office. Please take a few moments to complete this form. This will help us get to know you better, so that we may provide the best care for your particular needs.

Name ____________________ Birthdate ____________________ Age __________

Reason for your visit ________________________________________

| | Yes | No |
|---|---|---|
| Are you in good health now | ❑ | ❑ |
| Are you now under the care of a physician? | ❑ | ❑ |

If so, what condition(s) is being treated? ________________________________________

________________________________________

________________________________________

If you use tobacco (smoke/smokeless), indicate how much. ________________________________________

If you drink alcoholic beverages, indicate how much. ________________________________________

If you are pregnant, please give the due date. ________________________________________

**Do you have or have you had any of the following?**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Marked Weight Change | ❑ | ❑ | Chest pains/discomfort | ❑ | ❑ |
| Eruption (rash) hives | ❑ | ❑ | Heart attack/trouble | ❑ | ❑ |
| Glaucoma | ❑ | ❑ | Irregular heart beat | ❑ | ❑ |
| Hearing Problems | ❑ | ❑ | Heart murmur | ❑ | ❑ |
| Sinus Problems | ❑ | ❑ | Heart valve problems | ❑ | ❑ |
| Stroke | ❑ | ❑ | High blood pressure | ❑ | ❑ |
| Headaches | ❑ | ❑ | Pacemaker | ❑ | ❑ |
| Convulsions/epilepsy | ❑ | ❑ | Heart surgery | ❑ | ❑ |
| Numbness/tingling | ❑ | ❑ | Hepatitis/liver problems | ❑ | ❑ |
| Psychiatric treatment | ❑ | ❑ | Immune problems | ❑ | ❑ |
| Tuberculosis | ❑ | ❑ | Stomach/intestinal problems | ❑ | ❑ |
| Emphysema | ❑ | ❑ | Kidney disease | ❑ | ❑ |
| Asthma | ❑ | ❑ | Venereal Disease | ❑ | ❑ |
| Shortness of breath | ❑ | ❑ | Excessive bleeding/bleeding problems | ❑ | ❑ |
| Diabetes | ❑ | ❑ | Anemia | ❑ | ❑ |
| Thyroid condition | ❑ | ❑ | Blood transfusion | ❑ | ❑ |
| Rheumatic fever | ❑ | ❑ | Radiation therapy | ❑ | ❑ |
| Arthritis/rheumatism | ❑ | ❑ | Tumors or growths | ❑ | ❑ |
| Artificial joints | ❑ | ❑ | Cancer | ❑ | ❑ |

Please list all medications and supplements you are currently taking. ________________________________________

________________________________________

________________________________________

________________________________________

Are you allergic to any medications? If so, please list. ________________________________________

________________________________________

________________________________________

(continued)

Have you ever had surgery or a serious medical illness? If so, please describe. ________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Is there any disease, condition or problem not listed that you think we should know about, or is there any activity your doctor says you cannot do? If so, please explain. ________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

**Physician's Name** ______________________________ **Phone #:** ______________________________

**Dentist's Name** ______________________________ **Phone #:** ______________________________

Does dental treatment make you nervous? No ____ Slightly _____ Moderately _____ Extremely ______

Do you have any of the following problems?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Burning tongue/lips | ❑ | ❑ | Difficulty opening or closing jaws | ❑ | ❑ |
| Frequent blisters, lips/mouth | ❑ | ❑ | Clicking/popping jaw | ❑ | ❑ |
| Periodontal (gum) disease | ❑ | ❑ | Clenching/grinding | ❑ | ❑ |

If there are any changes, please inform our office as soon as possible.

To the best of my knowledge, my answers are true and correct.

Signature of Patient, or Legal Guardian ________________________________________ Date ____________________