WASHINGTON ORAL AND MAXILLOFACIAL SURGERY

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HEALTH HISTORY

Name _____ Age _____ Date_____
Height_____ Weight _____

Have you **ever** had any serious illnesses, operations or hospitalizations? If yes, please describe: ☐ Yes ☐ No

_____

_____

_____

Please list all medications that you are currently taking:

Please check if you have or ever had the following:

☐ Heart murmur	☐ Stroke	☐ Chest pain
☐ Radiation (X-ray) treatment for cancer	☐ Diabetes	☐ Colitis
☐ Implants or artificial prostheses	☐ Asthma	☐ Tuberculosis
☐ Liver disease, including cirrhosis	☐ Sinusitis	☐ Dizziness
☐ Hepatitis	☐ Seizures or epilepsy	☐ Thyroid disease
☐ Heart attack	☐ Kidney disease	☐ Palpitations
☐ Heart disease	☐ Fainting spells	☐ Shortness of breath
☐ High blood pressure	☐ Chemical dependency	☐ Arthritis
☐ Stomach ulcers	☐ Emotional disorder	☐ Glaucoma

Have you ever taken any of the following medications for treatment of osteoporosis or cancer? ☐ Yes ☐ No
Fosamax, Actonel, Boniva, Didronel, Skelid, Aredia, Zometa

Are you currently taking any blood thinners? ☐ Yes ☐ No
Coumadin, Warfarin, Plavix, Aspirin, or others ☐ Yes ☐ No

Have you ever been told that you have sleep apnea? ☐ Yes ☐ No

Do you bruise easily or have any bleeding disorders? ☐ Yes ☐ No

Do you smoke or chew Tobacco? ☐ Yes ☐ No

How much per day? _____ For how long? _____

Continued on back.

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HEALTH HISTORY - continued

Do you have clicking or popping of jaw joint or difficulty opening?	☐ Yes	☐ No
Do you have any disease drug or condition that has depressed your immune system?	☐ Yes	☐ No
Have you had any serious problems associated with any previous dental treatment?	☐ Yes	☐ No
Have you or a family member had any problem associated with intravenous anesthesia?	☐ Yes	☐ No
Do you get carsick or seasick easily?	☐ Yes	☐ No
Are you Pregnant, or ***is there any chance*** you might be Pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Is there a past history of alcohol or chemical dependency?	☐ Yes	☐ No
Do you have any medical or dental problems that you think we should know about?	☐ Yes	☐ No
Is there anything you wish to speak about in private with the doctor?	☐ Yes	☐ No
Are you currently using Oral Contraceptives?	☐ Yes	☐ No

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Please check if you are allergic to or ever have been allergic to:

☐ Local Anesthesia (Novocain, etc.)	☐ Aspirin	☐ Ibuprofen
☐ Penicillin	☐ Codeine	☐ Percocet
☐ Clindamycin	☐ Vicodin	☐ Latex or Rubber Products
☐ Sulfa	☐ Sedatives, Barbiturates	☐ Dairy products (Milk, eggs, etc.)

Please list all other allergies not listed above? _____

_____

_____

_____

If yes to above, what is the allergic reaction? _____

_____

_____

_____

I understand the information I provide on this form is essential to determine my dental needs and the provision of treatment. I understand that if any change occurs in my health I must report it to the office as soon as possible. I have read and understand these questions and answered them all truthfully and to the best of my ability.

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

Signature of Person Completing Health History _____ Date _____