MANCHESTER ORAL SURGERY

Health History Form

Patient's Name: _____ Date of Birth: _____/_____/_____

Gender: _____ Age: _____ Height: _____ Weight: _____

Home address: _____

_____

Home/cell phone: _____ E-mail: _____

General dentist: _____ Primary Care Physician: _____

The following questions are important for your treatment, so please respond honestly and completely. Please circle your responses.

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes ☐ No ☐

If yes, please describe: _____

Are you now under a doctor's care for a particular problem at this time? Yes ☐ No ☐

If yes, why? _____

Have you ever been hospitalized or had a serious illness? Yes ☐ No ☐

If yes, why? _____

Have you ever had surgery? Yes ☐ No ☐ If yes, any complications from anesthesia (malignant hyperthermia)? Yes ☐ No ☐

Year of surgery: _____ Reason for surgery: _____

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PERSONAL MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, high cholesterol, stroke, irregular heartbeat, heart surgery, pacemaker)? Yes ☐ No ☐

Diabetes? Yes ☐ No ☐

Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)? Yes ☐ No ☐

Bleeding disorder, blood thinners, anemia, bleeding tendency, blood transfusion? Do you bruise easily? Yes ☐ No ☐

Liver disease (jaundice; hepatitis A, B, or C)? Yes ☐ No ☐

Kidney disease or kidney failure, requiring dialysis? Yes ☐ No ☐

Stomach ulcers or colitis? Yes ☐ No ☐

Frequent or recurring mouth sores? Yes ☐ No ☐

Any cancer, radiation, or chemotherapy? Yes ☐ No ☐

Describe: _____

Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? Yes ☐ No ☐

Sinus or nasal problems? Yes ☐ No ☐

Sleep apnea? Yes ☐ No ☐

Jaw joint pain, clicking, popping, and/or difficulty with mouth opening? Yes ☐ No ☐

Arthritis? Yes ☐ No ☐

Osteoporosis or osteopenia? Yes ☐ No ☐

Thyroid disease? Yes ☐ No ☐

Significant weight loss or gain? Yes ☐ No ☐

Seizures, epilepsy, fainting, and/or dizziness? Yes ☐ No ☐

Glaucoma? Yes ☐ No ☐

Any chance that you might be pregnant? Yes ☐ No ☐

Date of your last treatment: _____/_____/_____

Do you have any other disease, condition, or problem <u>not listed above</u> that you think the doctor should know about? Yes ☐ No ☐

If yes, please explain: _____

Health History Form (continued)

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes ☐ No ☐	Pain medication?	Yes ☐ No ☐
Anti-coagulants (blood thinners)?	Yes ☐ No ☐	Anti-seizure medication?	Yes ☐ No ☐
Steroids (prednisone, methylprednisolone)?	Yes ☐ No ☐	Bone density medication, either by mouth or injected (used to treat osteoporosis/osteopenia or to prevent bone metastasis from cancer)?	Yes ☐ No ☐
Insulin?	Yes ☐ No ☐		

Please list any specific medications indicated above, and/or any other medications not listed above, that you are currently taking (including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals):

Medication	Medication	Medication

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Valium, diazepam, or other sedatives?	Yes ☐ No ☐	Penicillin, amoxicillin, or other antibiotics?	Yes ☐ No ☐
Aspirin, Tylenol, Aleve, or ibuprofen?	Yes ☐ No ☐	Percocet, Vicodin, codeine, or other pain killers?	Yes ☐ No ☐
Latex, Tegaderm, or tape?	Yes ☐ No ☐	Milk, eggs, or other food products?	Yes ☐ No ☐

Have you or another family member had any problem with general anesthesia, conscious sedation, or local anesthesia? Yes ☐ No ☐

If yes, which anesthetic? _____ Reaction: _____ Relationship: _____

Other drug or food allergies not listed above: _____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes ☐ No ☐ If yes, how many packs per day and for how long? _____

Do you have a history of alcoholism or drug addiction? Yes ☐ No ☐ If yes, to what were you addicted? _____

Do you use:

Alcohol?	Yes ☐ No ☐	How often? _____
Marijuana?	Yes ☐ No ☐	How often? _____
Recreational Drugs?	Yes ☐ No ☐	How often? _____

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

_____ _____ _____

Patient's (or legal guardian's) signature | Date | Doctor's initials