

PATIENT HEALTH HISTORY

Patient Name _____ Date ____/____/____

Date of Birth ____/____/____ Age _____ Height _____ Weight _____ lbs Did you bring xrays? Y N

Referring Doctor _____ Medical Doctor _____ Previous patient here? Y N

Answer all questions by circling (Y) Yes or (N) No

All responses are kept confidential.

- 1. Are you in good health?..... Y N
- 2. Has there been any change in your general health in the past year?..... Y N
If yes, please explain _____
- 3. Date of last physical exam ____/____/____
- 4. Are you under a physician's care for a particular problem?..... Y N
If yes, please explain _____
- 5. Have you ever had any serious illnesses, operations or hospitalizations?..... Y N
If yes, please explain _____

- G. Heart Surgery?..... Y N
If yes, please explain _____
- H. Arthritis?..... Y N
- I. Lung Disease (Asthma, Emphysema, Chronic or Severe Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath)..... Y N
If yes, please explain _____
- J. Seizures, Convulsions, Epilepsy, Fainting or Dizziness or TIA's?..... Y N
If yes, please explain _____
- K. Bleeding Disorder, Anemia, Hemophilia?..... Y N
If yes, please explain _____

6. ARE YOU USING ANY OF THE FOLLOWING:

- A. Antibiotics?..... Y N
- B. Anticoagulants (Blood Thinners, i.e. Plavix or Coumadin)?..... Y N
If yes, please list _____
- C. Aspirin or drugs such as Aleve or Motrin?..... Y N
- D. High Blood Pressure Medication?..... Y N
- E. Steroids (Cortisone, etc.)?..... Y N
- F. Tranquilizers?..... Y N
- G. Insulin or Oral Anti-Diabetic Drugs?..... Y N
If yes, please explain _____
- H. Digitalis, Inderal, Nitroglycerin or other heart drug?..... Y N
- I. Are you taking or have you ever taken Bisphosphonates (Fosamax or Actonel) for Osteoporosis, or chemotherapy for multiple myeloma, etc.?..... Y N
If yes, please explain _____
- J. Please list any and all medications including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

- L. Do you bruise easily?..... Y N
- M. Liver Disease (Jaundice, Hepatitis)?..... Y N
If yes, please explain _____
- N. Kidney Disease?..... Y N
If yes, please explain _____
- O. Implants placed anywhere in your body (Hip, Knee, Heart Valve, Pacemaker)?..... Y N
If yes, please explain _____
- P. Glaucoma?..... Y N
- Q. Diabetes?..... Y N
- R. Stomach ulcers or intestinal problems?..... Y N
- S. Thyroid Disease?..... Y N
- T. Do you snore?..... Y N
- U. Do you have sleep apnea?..... Y N
If yes, do you use any breathing devices? Y N
If yes, please list _____
- V. Radiation (x-ray) treatment for cancer?..... Y N
- W. Clicking or Popping of jaw joint, pain near ear, difficulty opening mouth?..... Y N
If yes, please explain _____
- X. Do your grind or clench your teeth?..... Y N
- Y. Sinus or Nasal problems?..... Y N
If yes, please explain _____
- Z. Any disease, drug or transplant operation that has depressed your immune system?.... Y N
If yes, please explain _____
- AA Do you have a history of cold sores?..... Y N

Have you taken or been given a prescription for a narcotic medication within the past month?..... Y N

7. DO YOU HAVE OR HAVE YOU EVER HAD:

- A. Rheumatic Fever/Rheumatic Heart Disease?.. Y N
- B. Congenital Heart Disease?..... Y N
- C. Cardiovascular Disease (Heart Attack, Heart Trouble, Coronary Artery Disease, Angina, Palpitations, Chest pain, Erratic Heartbeat?.... Y N
If yes, please explain _____
- D. Heart Murmur?..... Y N
- E. High Blood Pressure?..... Y N
- F. Stroke?..... Y N

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

- A. Local anesthesia?..... Y N
- B. Penicillin or other antibiotics?..... Y N
- C. Sedatives or Barbiturates?..... Y N
- D. Aspirin or Ibuprofen?..... Y N
- E. Codeine or other pain killers?..... Y N
- F. Latex or Rubber Products?..... Y N
- G. Please list other allergies: _____

Please explain any **yes** answers: _____

9. Do you smoke or chew Tobacco?..... Y N
If yes, how much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?..... Y N
If yes, please explain: _____
11. Have you had any serious problems associated with any previous dental treatment?..... Y N
If yes, please explain: _____
12. Have you or an immediate family member had any problem associated with IV sedation or general anesthesia?..... Y N
If yes, please explain: _____
13. Family history of Malignant Hyperthermia? Y N
If yes, please explain: _____
- Have you had anything to eat or drink today? Y N
If yes, please list: _____

14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?..... Y N
If yes, please explain: _____
15. Do you wish to talk with the doctor privately about anything?..... Y N

- 16. FOR WOMEN ONLY:**
- A. Are you pregnant?..... Y N
B. Is there **any chance** you might be pregnant?.. Y N
C. Are you nursing?..... Y N
D. 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 other means 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 Medical Doctor for further guidance.

Initial _____

Chief complaint or reason for visit: _____

If trauma, date of accident and brief description: _____

In case of emergency, notify: _____ Phone Number: _____

Relationship to patient: (Circle one) Parent Spouse Sibling Relative _____ Other _____

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I authorize the release of my records to my referring physician and my insurance carrier. The information above is true and correct to the best of my knowledge. I acknowledge that I have received a copy of Florida Oral and Facial Surgical Associate's Notice of Privacy Practices. This Notice describes how Florida Oral & Facial Surgical Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Signature (Patient or Parent if Minor) _____ Date _____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

Date: _____ Doctor's Signature _____