ORAL & FACIAL SURGERY CENTER of VIRGINIA

HEALTH HISTORY

Please complete the Health History so that we may provide the best possible care; the doctor will discuss the History with you prior to beginning treatment.

I. GENERAL INFORMATION

Height_________________________ Weight_______________________

Are you in good health? YES NO (circle)

Are you now under a physician's care for a particular problem? If so, describe:___________________________________

____

Physician name and telephone # ____

Date of last physical exam ____

Has there been any change to your general health in the past year? If so, describe:

____

Have you ever had any serious illness? If so, describe:

____

Have you been hospitalized or had surgery? If so, describe:

____

II. DO YOU HAVE OR HAVE YOU EVER HAD: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Cardiovascular disease? (heart attack, coronary artery disease, angina, chest pain, irregular heart rate or palpitations, congenital heart disease, rheumatic heart disease, murmur)
2. High Blood pressure?
3. Stroke?
4. Heart Surgery? (bypass or stent)
5. Pacemaker?

15. Thyroid disease?
16. Arthritis?
17. Stomach ulcers or acid reflux? (GERD)
18. Other GI disease?
19. Glaucoma?
20. Osteoporosis?
21. Implants or joint replacements?

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6. Respiratory disease? (asthma, emphysema, COPD, chronic cough, bronchitis)
7. Epilepsy or seizures?
8. Fainting or dizziness?
9. Bleeding disorder, anemia?
10. Blood transfusion?
11. Bruise or bleed easily?
12. Liver disease? (jaundice, hepatitis)
13. Kidney disease?
14. Diabetes? (Type?)

22. Radiation therapy?
23. Chemotherapy?
24. Sinus or nasal problems?
25. Seasonal allergies?
26. Snoring or sleep apnea?
27. Psychiatric illness?
28. Disease or medication that has depressed your Immune system?
29. Organ transplant?

III. ARE YOU TAKING ANY OF THE FOLLOWING: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Antibiotics?
2. Anticoagulants or blood thinners? (Coumadin, Plavix)
3. Aspirin or ibuprofen?
4. Steroids? (cortisone, prednisone, etc.)
5. Tranquilizers, sleep aids, antidepressants, narcotics?
6. Insulin or oral anti-diabetic drugs?
7. Please list **ALL** medications you are taking, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:

____

____

____

Have you ever taken?

8. Diet pills?
9. Bisphosphonate bone density medications? (Reclast, Foasmax, Actonel, Boniva, Aredia, Zometa)
10. Have you ever been advised to **not** take a medication?

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IV: ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Local anesthesia? (novocain, etc.)
2. Penicillin or other antibiotics?
3. Sedatives, barbiturates?
4. Aspirin or ibuprofen?
5. Codeine or other pain killers?
6. Latex or rubber products?
7. Chemicals or jewelry? (rash or sensitivity)
8. Food products? Soy? Eggs?
9. Other allergies or reactions?

   If so, please list: ______________________

   ____

V. ADDITIONAL INFORMATION: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Do you smoke or chew tobacco?

   How much?______________ For how long?__________

2. Is there any past history of alcohol or chemical dependency?
3. Is there any emotional or psychiatric illness that may affect the care we provide?
4. Have you had any serious problems associated with previous dental treatment?
5. Do you grind or clench your teeth?
6. Have you or an immediate family member had any problem associated with anesthesia?
7. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?
8. Do you have pain, clicking or popping of the jaw joint, or difficulty opening mouth?
9. Do you wish to talk to the doctor privately about anything?

VI: FOR FEMALE PATIENTS ONLY

1. Are you pregnant, or is there any chance you might be pregnant?

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2. Are you nursing?

   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.

I understand the importance of a truthful and complete health history to assist the doctor in providing the best possible care. I have read and understand the above information.

Patient/Guardian signature:____ Date:_______________________________

Physician Signature:____Date:______________________________