Implants & Orofacial Surgery Specialists

Health History Form

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

Referring Doctor _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

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

If yes, why? _____ Date of last physical exam ____/_____/_____

List prior operations: _____

_____

PATIENT 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, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Arthritis?	Yes	No
Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any cancer, radiation, or chemotherapy? Yes No

Describe: _____Date of your last treatment? _____

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

If yes, please explain: _____

FEMALE PATIENT

Are you pregnant, or is there any chance you might be pregnant? Yes No Not Applicable

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Prescription pain medication?	Yes	No

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Anticoagulants (blood thinners)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No
Antianxiety agents, antidepressants or other psychiatric medications?	Yes	No	Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use. _____ _____	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 **Dosage**

ALLERGIES

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

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug or food allergies not listed above:

_____

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:

Substance abuse? Yes No

Do you use:

Alcohol? Yes No How often? _____

Marijuana? Yes No How often? _____

Recreational drugs? Yes No How often? _____

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DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?
_____
_____
___

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.

_____ _____
_____
Signature of patient, parent, guardian Date

_____
_____
Printed name of patient, parent, guardian/Relationship

_____