HEALTH HISTORY

SOUTHERN WEST VIRGINIA ORAL & MAXILLOFACIAL SURGEONS, LTD

Patient Name: _____ Date of Birth: _____ Height: _____ Weight:_____ Age:_____

Physician Name:_____ Dentist Name: _____ Orthodontist Name: _____

Reason for Visit: _____ How were you referred to us?_____ Date:_____

Answer all questions by circling Yes (Y) or No (N). All responses are kept completely 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
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? .....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:.....Y N

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6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   - B. Congenital Heart Disease? .....Y N
   - C. Cardiovascular Disease (□Heart Attack □Heart Trouble □Heart Murmur □Coronary Artery Disease □Angina □High Blood Pressure □Stroke □Palpitations □Heart Surgery □Pacemaker)? ……Y N
   - D. Lung Disease(□Asthma □Emphysema □COPD □Chronic Cough □Bronchitis □Pneumonia □Tuberculosis □Shortness of Breath □Chest Pain, □Severe Coughing □Sleep apnea)?.....Y N
   - E. □Seizures □Convulsions □Epilepsy □Fainting or □Dizziness? .....Y N
   - F. □Bleeding Disorder □Anemia □Bleeding Tendency □Blood Transfusion □Do you bruise easily?.....Y N
   - G. Liver Disease (□Jaundice □Hepatitis)? .....Y N
   - H. Kidney Disease?.....Y N
   - I. Diabetes?.....Y N
   - J. Thyroid Disease (Goiter)?.....Y N
   - K. Arthritis?.....Y N
   - L. Stomach Ulcers or Colitis?.....Y N
   - M. Glaucoma?.....Y N
   - N. Osteoporosis?.....Y N
   - O. Implants placed anywhere in your body □Heart Valve □Pacemaker □Hip, Knee?.....Y N
   - P. Radiation (X-ray) treatment for Cancer? .....Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?.....Y N
   - R. Sinus or Nasal problems?.....Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? .....Y N
   - T. Infections or Infectious disease: □ HIV/AIDS □ MRSA/"Mersa" □ Colitis from Antibiotic use.……..Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (Blood Thinners)? .....Y N
   - C. Methadone or Suboxone treatment? …… Y N
   - D. Aspirin .....Y N
   - E. High Blood Pressure medications? .....Y N
   - F. Steroids (Cortisone, Prednisone, etc.)? .....Y N
   - G. Tranquilizers?.....Y N
   - H. Insulin or Oral Anti-Diabetic drugs? .....Y N
   - I. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - J. Are you taking or ***have you ever taken*** Bisphosphate-nates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa) ? .....Y N
   - K. Have you ever had a bone density scan? .....Y N
   - L. Have you ever been advised <u>not</u> to take a medication? .....Y N
   - M. **Please list any and all medications taken**, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals (provide list if necessary): _____

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8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION (Hives, Rash, Itching) TO:**
   - A. Local Anesthesia (Novacaine, etc.)? .....Y N
   - B. Antibiotics (Penicillin, Erythromycin, etc.)? .....Y N
   - C. Sedatives, 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. Metal of any kind?.....Y N
   - H. Chemicals or jewelry (rash or sensitivity)?.....Y N
   - I. Food products?.....Y N
   - J. **Please list any other allergies and/or reactions**: Y N

     _____

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9. Do you smoke or chew Tobacco?.....Y N
   How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the anesthesia care we provide you? ……..Y N
11. Have you had any serious problems associated with any previous dental treatment?.....Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia?.....Y N
13. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant?.....Y N
    - B. Are you nursing?.....Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?.....Y N
15. Do you wish to talk to the doctor privately? about anything? .....Y N

I understand the importance of a truthful and complete Health History to assist my oral surgeon in providing the best care possible. I have had the opportunity to discuss my Health History with my oral surgeon.

_____ _____ _____

Date | Signature of Person Completing Health History | Reviewing Doctor's Initials