ORANGE TREE
ORAL SURGERY & IMPLANT CENTER

Patient's Name_____ Date of Birth_____

Gender: Male/ Female Height_____Weight_____

Health History Form

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.

Please describe your current health: Excellent Good Fair Poor

Date of last physical exam ____/_____/_____ Name of Primary Care Physician _____

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

If yes, why? _____

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	AIDS or HIV Positive?	Yes	No
			Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
			Glaucoma?	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	Diabetes?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Bone medications, such as bisphosphonates or prolia?	Yes	No	Obstructive Sleep Apnea? Bad Snoring?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any disease, chemotherapy or transplant operation? Cancer? Yes No

If so, where? _____, and when was the 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: _____

ANESTHESIA HISTORY

Any self or family history of issues with anesthesia? Yes No

If yes, please explain: _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

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MEDICATIONS

Please list your medications you have taken or are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

_____

_____

_____

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

Other drug allergies not listed above: _____

SOCIAL HISTORY

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

Have you ever sought professional care or been hospitalized for:

			Do you use:			
Drug abuse?	Yes	No	Alcohol?	Yes	No	How often? _____
Emotional disorders?	Yes	No	Marijuana?	Yes	No	How often? _____
Alcoholism?	Yes	No	Recreational drugs?	Yes	No	How often? _____

DENTAL HISTORY

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

Do you wish to talk to the doctor privately about anything? Yes No

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 Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature
_____	_____	_____
_____	_____	_____