HERMITAGE
ORAL & MAXILLOFACIAL SURGERY

HEALTH HISTORY FORM

Patient's Name _____ **Date of Birth** _____/_____/_____ **Age** _____

Gender _____ **Height** _____ **Weight** _____

An accurate and complete health history will assist in coordinating your dental care.
Please speak with the doctor or staff if there are any questions about this form.

DENTAL HISTORY

Please describe why you are in the office today_____

Are you having any dental discomfort at this time? Yes / No

If yes, please describe_____

MEDICAL HISTORY

Are you now under a doctor's care for a medical condition? Yes / No

Name of physician_____ Physician phone number_____

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

If yes, please describe_____

Have you ever had surgery? Yes / No

If yes, please describe_____

MEDICAL HISTORY (continued) - Do you have, or have you ever had, any of the following conditions:

Congenital heart disease, cardiovascular disease – like heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker?	Yes / No	Lung disease – like asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?	Yes / No
Implants placed anywhere in the body – like heart valve, pacemaker, hip, knee?	Yes / No	Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily?	Yes / No
Kidney disease or kidney failure?	Yes / No	Liver disease – like jaundice, hepatitis A/B/C?	Yes / No
Thyroid disease?	Yes / No	Arthritis?	Yes / No
Stomach ulcers or colitis?	Yes / No	Significant weight loss or gain?	Yes / No
Diabetes?	Yes / No	Sinus or nasal problems?	Yes / No
Glaucoma?	Yes / No	Sleep apnea?	Yes / No
Cancer?	Yes / No	Osteoporosis or osteopenia?	Yes / No
		Radiation to the head or neck?	Yes / No

Do you have any other medical conditions that are important for your doctor to know about? Yes / No

If yes, please describe_____

_____

_____

FAMILY MEDICAL HISTORY - Do you have a family history of any of the following conditions?

Diabetes? Yes / No Relationship_____

Heart disease? Yes / No Relationship_____

Lung disease? Yes / No Relationship_____

Bleeding problems? Yes / No Relationship_____

Cancer? Yes / No Relationship_____

Has an immediate family member had any problems with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No If yes, please describe_____

MEDICATIONS – Are you currently prescribed or taking any of the following:

Antibiotics?	Yes / No	Prescription pain medication?	Yes / No
Anticoagulants or 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 – like cortisone or prednisone?	Yes / No	Blood pressure medications?	Yes / No
Antianxiety agents, antidepressants, or other psychiatric medications?	Yes / No	Bisphosphonates or other medications to strengthen your bones?	Yes / No
Cancer or chemotherapy drugs?	Yes / No	Any other medications or supplements?	Yes / No

MEDICATIONS (continued): Please list the specific medications indicated above and/or any other medications not listed above that you are currently taking. Please including all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

Medication and dose	**Medication and dose**

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

Latex?	Yes / No	Codeine or other pain control medications?	Yes / No
Food or food products?	Yes / No	Aspirin, ibuprofen (Motrin), or naproxen (Aleve)?	Yes / No
Sedatives or barbiturates?	Yes / No	Penicillin or other antibiotics?	Yes / No
Any other medications?	Yes / No	Any other allergies?	Yes / No
Egg or soy?	Yes/No		

If yes, please describe_____

ANESTHESIA HISTORY

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No

If yes, please describe_____

FEMALE PATIENTS Are you pregnant? Yes / No Is there any chance you might be pregnant? Yes/No

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes / No

If yes, for how long?_____

Do you currently smoke? Yes / No

Have you ever sought professional care or been hospitalized for:

Substance abuse Yes / No

Emotional disorders Yes / No

Alcoholism Yes / No

Do you use:

Alcohol? Yes / No

If yes, how often per week?_____

Marijuana? Yes / No

If yes, how often per week?_____

Recreational drugs? Yes / No

If yes, how often per week?_____

DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? Yes / No

I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient or legal representative Date

_____

Printed name of patient or legal representative

_____ _____

Doctor's Signature Date