STATEN ISLAND
ORAL & MAXILLOFACIAL
SURGERY

HEALTH HISTORY

PATIENT'S NAME: _____ TODAY'S DATE: _____

ANSWER ALL QUESTIONS BY CIRCLING YES OR NO

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 currently 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. Height: _____ Weight: _____

DO YOU HAVE OR HAVE YOU EVER HAD:

7. Rheumatic fever or rheumatic heart disease? Y N
8. Congenital heart disease? Y N
9. Cardiovascular disease (heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker)? Y N
10. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? Y N
11. Seizures, convulsions, epilepsy, fainting, dizziness, psychiatric treatment, or other nervous disorder? Y N
12. Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily? Y N
13. Liver disease (jaundice, hepatitis)? Y N
14. Kidney disease? Y N
15. Diabetes? Y N
16. Thyroid disease (goiter)? Y N
17. Arthritis? Y N
18. Stomach ulcers or colitis? Y N
19. Glaucoma? Y N
20. Implants placed anywhere in your body (heart valve, pacemaker, hip, knee)? Y N
21. Radiation (x-ray) treatment for cancer? Y N
22. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
23. Sinus or nasal problems? Y N
24. Any disease, drug, or transplant operation that has depressed your immune system? Y N
25. HIV, AIDS, or ARC? Y N

ARE YOU USING ANY OF THE FOLLOWING?

26. Antibiotics? Y N
27. Anticoagulants (blood thinners)? Y N
28. Aspirin/drugs such as Motrin (ibuprofen), Aleve? Y N
29. High blood pressure medications? Y N
30. Steroids (Cortizone, etc.)? Y N
31. Tranquilizers? Y N
32. Insulin or oral anti-diabetic drugs? Y N
33. Digitalis, Inderal, nitroglycerin, or other heart drug? Y N
34. Any regular medicine, pills, or drugs (either over-the-counter or prescription)? If yes, please list:

_____

_____

_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY ADVERSE REACTION TO:

35. Local anesthesia (Novocain, etc.)? Y N
36. Penicillin or other antibiotics? Y N
37. Sedatives, barbiturates? Y N
38. Aspirin or ibuprofen? Y N
39. Codeine or other painkillers? Y N
40. Latex or rubber products? Y N
41. Other allergies or reactions? Please list:

_____

_____

42. Do you smoke or chew tobacco? Y N
    How much per day? _____
43. Is there any past history of alcohol or chemical dependency or an emotional disorder that may affect the care we provide you? Y N
44. Have you ever had any serious problems associated with any previous dental treatment? Y N
45. Have you or has an immediate family member had any problem associated with intravenous anesthesia? Y N
46. Do you have any other disease, condition, or problem not listed above that the doctor should know about? Y N
47. Do you wish to talk to the doctor privately about anything? Y N

FOR WOMEN ONLY:

48. Are you pregnant, or **is there any chance** you might be pregnant? Y N

If you are using oral contraceptives, it is important to understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control in place of one complete cycle of birth control pills after your course of antibiotics or other medication is completed. Please consult your physician for further guidance.

ALL RESPONSES ARE KEPT CONFIDENTIAL

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