Heritage Oral Surgery and Implant Centers

R. Dean Lang, D.D.S. *Payam Samouhi, D.D.S, M.D. apc*
Don Kim, D.D.S, M.D. apc

MEDICAL/DENTAL HEALTH HISTORY FOR ORAL AND MAXILLOFACIAL SURGERY

Patient Name: _____

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

Place of Birth: _____

The detailed health history is very important for our staff to have as an aid in your treatment. If you do not have a positive answer, simply write no. Please answer ALL questions completely. A yes answer may require some explanation. A nurse will be pleased to help you with any questions that you may have regarding this health history form. Thank you.

MEDICAL

1. Have you been examined by a physician within the past year?_____

If yes, for what reason?_____

_____

2. Has there been any change in your general health in the past year?_____

If yes, please explain: _____

_____

3. Are you currently being treated by a physician for a medical problem?_____

If yes, please explain: _____

_____

4. Please list any prescribed medication take within the past year:_____

5. Please list any medications that you are now taking:_____

_____

6. Have you ever been seriously ill or hospitalized? _____

_____

7. Have you had radiation treatment for any tumor or growth?_____

_____

8. Do you often feel fatigued or tired? _____

9. Do you have Diabetes? _____ Date of onset: _____

Controlled? _____ Medications: _____

10. Have you ever had any of the following conditions? Please list dates:

Arthritis _____ Colitis _____ Epilepsy _____ Jaundice _____

Multiple Sclerosis _____ Thrombophlebitis _____ Stomach Ulcers _____

11. Have you ever had or been exposed to any of the following communicable disease? Please list dates:

Mononucleosis _____ Hepatitis _____ Herpes _____

Venereal Disease_____ HIV _____ Tuberculosis _____

12. Have you ever received a blood transfusion, platelets, or plasma? _____

CARDIOVASCULAR

1. Do you have/ or have you been treated for chest pain (angina)? _____

2. Do you have high blood pressure? _____

3. Have you ever had a heart attack or stroke (CVA or TIA)? _____

4. Have you ever had an irregular heartbeat?_____

5. Have you ever had Rheumatic Fever? _____

6. Do you have a heart murmur or any heart defect? _____

7. Have you been told you need to take an antibiotic before dental work?_____

8. Do you take any medication to prevent clotting? _____

9. Do you have any blood disorders such as anemia? (thin blood)? _____

10. Have you ever been treated for vascular problems? _____

11. Have you ever had an excessive bleeding problem?_____

12. Have you ever taken Fen Phen (weight loss pill)? _____

13. Do your ankles ever swell? _____

14. Have you had open-heart surgery? _____ angioplasty?_____angiogram? _____

RESPIRATORY

1. Do you have a persistent cough? _____

2. Are you ever short of breath with mild exertion?_____

3. Do you have asthma? _____

4. Do you have emphysema? _____

5. Do you have bronchitis?_____

6. Have you ever been a heavy smoker? _____

ALLERGIES

1. Have you ever experienced an unfavorable reaction to any of the following medications of foods?

If yes, please indicate the type of reaction:

Latex _____ Penicillin _____ Erythromycin _____ Codeine _____

Aspirin _____ Versed _____Propofol _____Demeol_____

Atropine _____ Sodium Brevital _____Soybean Oil _____ Egg _____

Lecithin _____ Glycerol_____Any other Medications_____

Please List Food Allergies _____
(If you have no known allergies please write "none" at the bottom)

NEUROLOGICAL

1. Do you have numbness or tingling in any part of your body?_____
2. Has any part of your body ever been paralyzed? _____
3. Have you ever had a convulsion / seizure? _____
4. Do you have frequent or severe headaches? _____
5. Have you ever had psychiatric treatment? _____
6. Do you have a tendency to faint? _____
7. Do you consider yourself to be a nervous person? _____
8. Have you suffered from severe nervous exhaustion (breakdown)?_____
9. Do you often feel unhappy or depressed? _____
10. Do you often cry? _____

11. Do you have a profound fear of dental or oral surgery treatment? _____

DISABILITY

1. Do you wear contact lenses? _____

2. Do you use a hearing aid? _____

3. Are you disabled in any way? _____

If yes please explain: _____

_____

_____

DENTAL

1. Have you had regular dental care? _____

2. Have you ever had an unfavorable reaction to local anesthetic (Xylocaine or Novocain) or any other dental material? _____

3. Have you previously had Sodium Brevital or Propofol in an Oral Surgery office? _____

4. Have you ever had an injury to the face, jaw, or neck? _____

5. Do you have difficulty opening your mouth wide? _____

6. Have you ever been diagnosed as having TMJ Syndrome or does your jaw joint ever “click”, “pop”, or have sharp pain or discomfort? _____

7. Have you had orthodontic care? _____Orthodontist Name? _____

8. Would you like a referral to a general dentist or orthodontist for further care? _____

9. Are you currently experiencing dental pain or swelling? _____

PERSONAL

1. Do you currently smoke/ use tobacco? _____Number of years:____ How many a day?_____

2. Do you drink alcohol? _____ How frequently? _____

3. Do you use marijuana or cocaine? _____ How frequently? _____

4. Do you have a history of drug abuse or been addicted to any drug?_____

5. Are you currently involved in a substance abuse program? _____

6. How do you consider your health to be? (**Please Circle One**)

Excellent Good Average Fair Poor

FOR LADIES ONLY

1. Are you pregnant?_____ If yes, what trimester? _____

2. Are you currently taking birth control pills? _____

3. Have you passed through menopause? _____

4. Have you ever had a hysterectomy or ovariectomy? _____

ANESTHESIA

1. For the purpose of the proposed surgical procedure do you prefer:

Local Anesthesia (Xylocaine or Novocain)?_____

Local Anesthesia and Nitrous Oxide? (laughing gas)? _____

I.V Sedation?_____

Deep Sedation/ General Anesthesia?_____

GENERAL

1. Please indicate any important medical or dental information not already covered by this questionnaire:

_____

_____

_____

PLEASE SIGN & DATE BELOW:

_____

Signature (Patient or Parent/Guardian of Patient) **Date**

_____

Reviewed by: **Doctor**

_____

Health History Reviewed and Updated

_____

Signature (Patient or Parent/Guardian of Patient) **Date**

_____

Reviewed by: **Doctor**