Oral and Maxillofacial Surgery
Health History Questionnaire

Name:_____ Date:_____

Please answer all questions by circling the best response. Your doctor will discuss your answers with you.

Reason for your visit: _____

How long have you had this condition? _____

General questions:

Is your general health good at present? YES NO
Are you under the care of a physician? YES NO
If so, why? _____

Have you been admitted to a hospital? YES NO
If so, why? _____

Heart Problems

Heart Attack/MI	YES	NO
Angina/Chest Pain	YES	NO
High Blood Pressure	YES	NO
Prosthetic Heart Value	YES	NO
Congestive Heart Failure	YES	NO
Heart Bypass/Stent Surgery	YES	NO
Congenital Heart Defect	YES	NO
Pacemaker/Defibrillator	YES	NO
Infective Endocarditis	YES	NO
Heart Palpitations	YES	NO
Irregular Heart Beat	YES	NO
Rheumatic Fever/ Rheumatic Heart Disease	YES	NO

Breathing Problems

Asthma	YES	NO
Tuberculosis	YES	NO
Sleep Apnea	YES	NO
Bronchitis/Emphysema/ COPD	YES	NO
Cough	YES	NO
Shortness of Breath	YES	NO
Pneumonia	YES	NO

Blood Problems

Anemia	YES	NO
Sickle Cell Disease	YES	NO
HIV disease/AIDS	YES	NO
Bleeding disorders (e.g. Hemophilia)	YES	NO
Coumadin/ Warfarin Treatment	YES	NO
Bruising Easily	YES	NO

Head, Eyes, Ears, Nose & Throat

Frequent Headache	YES	NO
Jaw Joint/TMJ Popping, catching, pain	YES	NO
Glaucoma	YES	NO
Sinus or nasal problems	YES	NO

Digestive Probems

Hepatitis/Jaundice	YES	NO
Liver Disease	YES	NO
GERD/Reflux/Ulcers	YES	NO

Endocrine Problems

Diabetes	YES	NO
Thyroid Disorders	YES	NO

Nervous System Problems

Stroke/TIA/MINI-Stroke	YES	NO
Epilepsy/Seizure Disorder	YES	NO
Neuropathy/Nerve Pain	YES	NO

Psychiatric Problems

Depression	YES	NO
Panic or Anxiety Disorder	YES	NO
Other Psychiatric or Emotional Disorder	YES	NO

Other Problems

Renal/Kidney/ Prostate Disease	YES	NO
Organ Transplant	YES	NO
Cancer/Tumors	YES	NO
Radiation or Chemotherapy Treatment	YES	NO
Arthritis	YES	NO
Artificial Joint/ Joint Replacement	YES	NO
Any Other Problems	YES	NO

For Women Only

Are You Nursing?	YES	NO
Are You (or could you be) Pregnant?	YES	NO

Family History

Cancer	YES	NO
Arthritis	YES	NO
Heart Disease	YES	NO
Hypertension	YES	NO
Anesthesia Complications	YES	NO

Social History

Smoking/Tobacco Use	YES	NO
Alcoholic Beverages	YES	NO
Recreational (Street) Drugs	YES	NO

Surgical History

Previous Operations	YES	NO

_____

_____

_____

Allergies (include reaction if known)

Aspirin	YES	NO
Pain Medicine(s)	YES	NO
Penicillin/Amoxicillin	YES	NO
Other Antibiotics	YES	NO
Local Anesthetics	YES	NO
Other Medicines	YES	NO
Latex or Glove Powder	YES	NO
Environmental/Seasonal	YES	NO
Other Allergies	YES	NO

Allergic Reaction:

_____

_____

_____

Medicines

Anticoagulants (blood thinners):

Aspirin	YES	NO
Coumadin	YES	NO
Plavix	YES	NO
Bisphosphonates (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa):	YES	NO
Other Medicines	YES	NO
Steroids	YES	NO
Birth Control Pill	YES	NO

List Drug Name and Dose:

_____

_____

_____

_____

_____

_____

_____

_____

Supplements (Diet Supplements, Natural or Herbal Vitamins):

_____

_____

_____

_____

Signature **Date**