HDA Hamilton Dental Associates

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# ORAL SURGERY HEALTH HISTORY

Date: ____________________________

Name: __________________________________________ Phone#: _____________________________________

Height: __________________ Weight: ______________________ Age: ________________

**Have you had or do you currently have any of the following conditions:**

| | Yes | No |
|---|---|---|
| Heart valve condition/murmur/surgery | ( ) | ( ) |
| History of rheumatic fever? | ( ) | ( ) |
| Coronary artery disease/Stents? | ( ) | ( ) |
| Chest pain or Angina? | ( ) | ( ) |
| Heart attack or Stroke, TIA history | ( ) | ( ) |
| High or Low blood pressure | ( ) | ( ) |
| History of Head Injury or concussion? | ( ) | ( ) |
| Thyroid condition? | ( ) | ( ) |
| History of Headaches of Migraines? | ( ) | ( ) |
| Ulcer, Reflux, gastritis, esophagitis? | ( ) | ( ) |
| Pneumonia, bronchitis, cough? | ( ) | ( ) |
| Asthma, Eczema, Allergic Rhinitus? | ( ) | ( ) |
| Simustitis / Nasal Problems | ( ) | ( ) |
| Snoring or Sleep apnea?, CPAP? | ( ) | ( ) |
| Difficulty breathing or short of breath? | ( ) | ( ) |
| Tuberculosis? | ( ) | ( ) |
| COPD or Emphysema? | ( ) | ( ) |
| Do you SMOKE? Or Chew tobacco? | ( ) | ( ) |
| Recreational/Illicit drug use/abuse? | ( ) | ( ) |
| Enzyme deficiency? | ( ) | ( ) |
| Immuno-suppressed/compromised | ( ) | ( ) |
| Infectious disease, Transplant? | ( ) | ( ) |
| CHRONIC PAIN management? | ( ) | ( ) |
| Delay in wound healing? | ( ) | ( ) |
| Chronic fatigue / night sweats? | ( ) | ( ) |
| Epilepsy or seizures? | ( ) | ( ) |
| Insomnia / Narcolepsy? | ( ) | ( ) |
| Cancer, chemotherapy, radiation? | ( ) | ( ) |
| Fainting or Syncope? | ( ) | ( ) |
| Gastic Bypass surgery? | ( ) | ( ) |
| Numbness? Weakness? | ( ) | ( ) |

| | Yes | No |
|---|---|---|
| Irregular heartbeat? pacemaker/defibrillator? | ( ) | ( ) |
| Artial Fibrillation, Heart block, palpitations? | ( ) | ( ) |
| Heart failure/disease, Heart/Bypass surgery? | ( ) | ( ) |
| Kidney or bladder condition or failure? | ( ) | ( ) |
| Diabetes or low blood sugar? | ( ) | ( ) |
| IBD, inflammatory bowel disease? | ( ) | ( ) |
| Ulcerative Colitus or Chrohn's disease? | ( ) | ( ) |
| Rheumatoid Arthritus, Lupus, Scleroderma? | ( ) | ( ) |
| Hepatitis?, Jaundice or Liver condition? | ( ) | ( ) |
| History of Blood transfusions? | ( ) | ( ) |
| Blood disorder / Anemia? | ( ) | ( ) |
| Do you bruise easily? Nosebleeds? | ( ) | ( ) |
| Bleeding tendency / Hemophilia | ( ) | ( ) |
| Gall bladder trouble/surgery? | ( ) | ( ) |
| Vertigo, Dizziness, Tinnitus, hear ringing? | ( ) | ( ) |
| Osteoarthritus/other joint condition? (Gout) | ( ) | ( ) |
| Osteoporosis/Osteopenia? | ( ) | ( ) |
| Maligant Hyperthermia? | ( ) | ( ) |
| History of MRSA infection? | ( ) | ( ) |
| Sexually Transmitted Diseases? or HIV? | ( ) | ( ) |
| Autism? Autism spectrum?, Tourettes? | ( ) | ( ) |
| Developmental delay? | ( ) | ( ) |
| Anxiety? Depression? ADD/ADHD? | ( ) | ( ) |
| Schizophrenia? Bipolar or Mood disorder? | ( ) | ( ) |
| Alcohol Abuse/Dependency? | ( ) | ( ) |
| Spine or Back injury or surgery? | ( ) | ( ) |
| Sensitive Gag Reflex? History of Nausea? | ( ) | ( ) |
| Orthopedic or joint surgery (fracture repair) | ( ) | ( ) |
| Previous Jaw/Facial fractures or surgery? | ( ) | ( ) |

Are you under the care of a physician now? Why? ______________________________________________

Have you ever been hospitalized? Why? ______________________________________________________

Any previous sedations or general anesthesia? Why? ___________________________________________

Have you or a family member had any problems with any type of anesthesia in the past? Yes No
Have you had any problems with previous dental extractions or a bad dental experience? Yes No

If yes, please explain: _____________________________________________________________________

continued on next page...

| | Yes | No |
|---|---|---|
| Any pain or clicking of your jaw, or grinding or clenching, or difficulty opening your mouth? | ( ) | ( ) |
| Do you need rest or become short of breath when climbing a flight of stairs? | ( ) | ( ) |
| If you are female: (A) Do you have regular menstrual periods? | ( ) | ( ) |
| (B) Are you pregnant? weeks? __________ Are you currently nursing a child? | ( ) | ( ) |
| Have you ever taken or been prescribed steroids, laxatives, diuretics, or amphetamines? | ( ) | ( ) |
| Do you suffer from an eating disorder or body dysmorphic disorder? (Anorexia, Bulimia) | ( ) | ( ) |
| Were you ever prescribed or have you ever taken any bone density/osteoporosis medications? | ( ) | ( ) |
| Bisphosponates? (Aredia, Zometa, Fosamax, Actonel, Reclast, Boniva, Xegva, Prolia?) | ( ) | ( ) |
| Blood thinner medications? (Aspirin, penicillin, sulfa, codeine, other?) | ( ) | ( ) |

Are you currently taking any kind of medication, drug, pills? Over The Counter or Prescription?

Please List: ____________________________________________

____________________________________________

Signature: ______________________________ Date: ________________