Klockner Road Office, 2929 Klockner Road, Hamilton Square, NJ 08690 (609) 586-6603
Merrill Lynch Campus, 1300 Merrill Lynch Drive 0301, Pennington, NJ 08534-4122 (609) 274-8484
Kuser Road Office, NJ Family Care, 2501 Kuser Road (2nd Floor), Hamilton Township, NJ 08691 (609) 689-1212

ORAL SURGERY HEALTH HISTORY

Name: _____ Phone#: _____

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

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

	Yes	No		Yes	No		Yes	No
Heart valve surgery/murmur/heart condition	( )	( )	Organ transplant	( )	( )	History of Blood transfusions	( )	( )
Rheumatic fever/congenital heart disease	( )	( )	Chronic pain management	( )	( )	Blood disorder / Anemia	( )	( )
Coronary artery disease/ Stents	( )	( )	Delay in wound healing	( )	( )	Bruise easily/ Nosebleeds	( )	( )
Chest pain or Angina	( )	( )	Chronic fatigue / night sweats	( )	( )	Bleeding tendency / Hemophilia	( )	( )
Heart attack, Stroke, TIA	( )	( )	Epilepsy or seizures	( )	( )	Gall bladder trouble/surgery	( )	( )
High or Low blood pressure	( )	( )	Insomnia / Narcolepsy	( )	( )	Vertigo, Dizziness, Tinnitus/Ear Ringing	( )	( )
History of Head Injury or concussion	( )	( )	Cancer, chemotherapy, radiation	( )	( )	Osteoarthritis/other joint condition (Gout)	( )	( )
Thyroid disease	( )	( )	Fainting or Syncope	( )	( )	Osteoporosis / Osteopenia	( )	( )
Headaches or Migraines	( )	( )	Gastric Bypass Surgery	( )	( )	Sexually Transmitted diseases, or HIV	( )	( )
Reflux, Ulcers, Gastritis, Esophagitis	( )	( )	Numbness, Weakness	( )	( )	Developmental delay, Autism, Tourette's	( )	( )
Pneumonia, bronchitis, chronic cough	( )	( )	Irregular heartbeat, pacemaker, defibrillators	( )	( )	Anxiety, Depression, ADD/ADHD	( )	( )
Asthma, Eczema, Allergic Rhinitis	( )	( )	Atrial Fibrillation, Heart block, palpitations	( )	( )	Schizophrenia, Bipolar or Mood disorder	( )	( )
Sinusitis / Nasal Problems	( )	( )	Heart failure/disease, Heart Bypass surgery	( )	( )	Alcohol Dependency/Alcoholism	( )	( )
Snoring or Sleep apnea, CPAP	( )	( )	Kidney or bladder condition (Nephritis)	( )	( )	Spine or Back injury or surgery	( )	( )
Difficulty breathing or short of breath	( )	( )	Dialysis, Kidney failure	( )	( )	Sensitive Gag Reflex, History of Nausea	( )	( )
Tuberculosis	( )	( )	Diabetes or low blood sugar	( )	( )	Orthopedic surgery/ ***joint replacement surgery***	( )	( )
COPD (Emphysema/Chronic Bronchitis)	( )	( )	IBD (inflammatory bowel disease)	( )	( )			
Enzyme deficiency	( )	( )	Ulcerative Colitis or Crohn's disease	( )	( )	Previous Jaw/Facial fractures or surgery	( )	( )
Immuno-suppressed/ compromised	( )	( )	Rheumatoid Arthritis, Lupus, Scleroderma	( )	( )			
Infectious disease/ MRSA infection	( )	( )	Hepatitis, Jaundice or Liver condition	( )	( )			

	Yes	No
Reason for today's visit: _____		
Have you had any problems with previous dental extractions or a bad dental experience?	( )	( )
If yes, please explain: _____		
Any pain or clicking of your jaw, grinding or clenching, or difficulty opening your mouth?	( )	( )
Please describe your current health: Excellent Good Fair Poor		
Are you under the care of a physician now? ____ Why? _____	( )	( )
Have you ever been hospitalized or had surgery?	( )	( )
If yes, please explain and provide dates_____		
Any previous sedations or general anesthesia? ____ Why? _____	( )	( )
Have you or a family member had any problem with any type of anesthesia in the past?	( )	( )
Have you had implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	( )	( )
Do you need rest or become short of breath when climbing a flight of stairs?	( )	( )
If you are female: (A) Are you pregnant, or is there any chance you might be pregnant? Weeks? _____	( )	( )
(B) Are you currently nursing a child?	( )	( )
Do you suffer from an eating disorder or body dysmorphic disorder (eg. Anorexia, Bulimia)?	( )	( )
Are you currently or have you ever taken steroids, laxatives, diuretics or amphetamines?	( )	( )
Were you ever prescribed or have you ever taken any bone density/osteoporosis medications?	( )	( )
_____Biphosponates (Aredia, Zometa, Fosamax, Actonel, Reclast, Boniva) _____RANKL Inhibitors (Xgeva, Denosumab, Prolia)		
_____Antiangiogenic Agents (Bevacizumab, Sunitinib, Sorafenib, Pazopanib, Axitinib) _____m-TOR Inhibitors (Everolimus, Temsirolimus)		
Are you currently or have you ever taken blood thinning medications?	( )	( )
(Aspirin, Coumadin/Warfarin, Plavix/Clopidogrel, Pradaxa, Xarelto, Aggrastat, Persantine, Eliquis, Arixtra)		
Are you currently or have you ever used recreational/illicit drugs (cocaine, heroin, marijuana, crystal meth, LSD, others)?	( )	( )
If yes, which drugs? _____		
Do you currently or have you ever had a medication or drug dependency (eg. Narcotics/opioids)?	( )	( )
If yes, which medications? _____		
Have you ever smoked, vaped or chewed tobacco? If yes, for how long? _____	( )	( )
Are you allergic to any foods or medications? (Aspirin, Penicillin, Sulfa, Codeine, Latex, other)	( )	( )
If yes, which foods or medications? _____		
Are you currently taking any kind of medication, drug or pill? Please include prescription and over the counter medications.	( )	( )

Please list: _____

_____

Signature: _____ Date: _____