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 allergic to any foods or 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: _____