

Northtowns Oral & Maxillofacial Surgery, PLLC
HEALTH HISTORY FORM

Patient's Name _____

Date of Birth ____/____/____

Gender _____

Height _____

Weight _____

Today's Date _____

An accurate and complete health history will assist in coordinating your dental care.
Please speak with the doctor or staff if there are any questions about this form.

DENTAL HISTORY

Please describe your current dental health (circle one): Excellent Good Fair Poor

Please describe why you are in the office today _____

Have there been any changes in your dental health in the past year? (circle one) Yes / No

If yes, please describe _____

Are you having any dental discomfort at this time? (circle one) Yes / No

If yes, please describe _____

Have you had any adverse effects from dental treatment? (circle one) Yes / No

If yes, please describe _____

Date of last dental visit? _____

DENTAL HISTORY - Do you have or have you ever had any of the following (circle yes or no):

Bleeding, sore gums?	Yes / No	Shifting in bite?	Yes / No
Unpleasant taste/bad breath?	Yes / No	Change in bite?	Yes / No
Swelling/lumps in mouth?	Yes / No	Burning tongue/lips?	Yes / No
Orthodontic treatment (braces?)	Yes / No	Frequent blister, lips/mouth?	Yes / No
Clenching/grinding?	Yes / No	Sensitive teeth (hot or cold?)	Yes / No
Sensitive to sweets?	Yes / No	Clicking/popping jaw?	Yes / No
Sensitive to biting?	Yes / No	Difficulty opening or closing jaw?	Yes / No
Food Impaction?	Yes / No	Loose teeth?	Yes / No
Biting cheeks/lips?	Yes / No		

MEDICAL HISTORY

Please describe your current overall health (circle one): Excellent Good Fair Poor

Have there been any changes in your general health in the past year? (circle one) Yes / No

If yes, please describe: _____

Are you now under a doctor's care for a medical condition? (circle one) Yes / No Date of last physical exam? _____

If yes, please describe _____

Name of physician _____ Physician phone number _____

Have you ever been hospitalized or had a serious illness? (circle one) Yes / No

If yes, please describe _____

Have you ever had surgery? (circle one) Yes / No

If yes, please describe _____

Do you have to premedicate prior to having any surgery? (circle one) Yes / No

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MEDICAL HISTORY (continued) - Do you have, or have you ever had, any of the following conditions (circle yes or no and **IF YES, PLEASE CIRCLE ALL THAT APPLY IF THERE ARE MULTIPLE CHOICES**):

Congenital heart disease, cardiovascular disease – like heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker?	Yes / No	Lung disease – like asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?	Yes / No
Implants placed anywhere in the body – like heart valve, pacemaker, hip, knee?	Yes / No	Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily?	Yes / No
Kidney disease or kidney failure, requiring dialysis?	Yes / No	Liver disease – like jaundice, hepatitis A, B, or C?	Yes / No
Thyroid disease?	Yes / No	Arthritis?	Yes / No
Stomach ulcers or colitis?	Yes / No	Significant weight loss or gain?	Yes / No
Diabetes?	Yes / No	Sinus or nasal problems?	Yes / No
Glaucoma?	Yes / No	Sleep apnea?	Yes / No
Cancer?	Yes / No	Osteoporosis or osteopenia?	Yes / No

If yes, type _____

Diagnosis date _____

Treatments _____

Do you have any other medical conditions that are important for your doctor to know about? (circle one) Yes / No

If yes, please describe _____

FAMILY MEDICAL HISTORY - Do you have a family history of any of the following conditions? (circle yes or no and list relationship):

Diabetes? Yes / No Relationship _____ Heart disease? Yes / No Relationship _____

Lung disease? Yes / No Relationship _____ Bleeding problems? Yes / No Relationship _____

Cancer? Yes / No Relationship _____

Has an immediate family member had any problems with local or general anesthesia and/or intravenous sedation? Yes / No If yes, please describe _____

MEDICATIONS – Are you currently taking any of the following? (circle yes or no) – **IF YOU ANSWER YES TO BIRTH CONTROL, LIST THE NAME OF IT; OTHERWISE, ALL OTHER MEDICATIONS ARE TO BE LISTED ON THE NEXT PAGE.**

Antibiotics?	Yes / No	Prescription pain medication?	Yes / No
Anticoagulants or blood thinners?	Yes / No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes / No
Heart medications?	Yes / No	Insulin or oral anti-diabetic drugs?	Yes / No
Steroids – like cortisone or prednisone?	Yes / No	Blood pressure medications?	Yes / No
Antianxiety agents, antidepressants, or other psychiatric medications?	Yes / No	Bisphosphonates or other medications to strengthen your bones?	Yes / No
Cancer or chemotherapy drugs?	Yes / No	Birth control medication? If yes, print name of birth control medication? _____	Yes / No
----- Are you able to swallow pills?	Yes / No		

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DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? (circle one) Yes / No

I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

Signature of patient, parent, guardian

Date

Printed name of patient, parent, guardian/Relationship

For office staff use - HEALTH HISTORY REVIEW

Date

Comments

Doctor's Signature

For office staff use - ADDITIONAL CLINICAL DOCUMENTATION

