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

HEALTH HISTORY FORM

Patient's Name _____

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? (If yes to **cancer**, please fill out below):	Yes / No	Osteoporosis or osteopenia?	Yes / No
If yes, type_____		Seizure Disorder?	Yes / No
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		

HEALTH HISTORY FORM

Patient's Name _____

MEDICATIONS (continued): Please list the specific medications in the APPROPRIATE COLUMNS (if you are providing a separate list of medications, please indicate which are over-the-counter by writing OTC next to it)

PRESCRIPTION medication and dose	OVER-THE-COUNTER medication, herbal or holistic remedies, vitamins or minerals

ALLERGIES – Are you allergic to or have you had an adverse reaction to (circle yes or no and list allergies):

Latex?	Yes / No	Codeine or other pain control medications?	Yes / No
Food or food products?	Yes / No	Aspirin, ibuprofen (Motrin), or naproxen (Aleve)?	Yes / No
Sedatives or barbiturates?	Yes / No	Penicillin or other antibiotics?	Yes / No
Any other medications?	Yes / No	Any other allergies?	Yes / No

If yes, please describe_____

ANESTHESIA HISTORY

Have you had any problem associated with local or general anesthesia and/or intravenous sedation? (circle one) Yes / No
If yes, please describe_____

FEMALE PATIENTS Are you pregnant? (circle one) Yes / No Is there any chance you might be pregnant? (circle one) Yes / No

SOCIAL HISTORY (circle yes or no)

Do you currently smoke, vape or chew tobacco? Yes / No
If yes, for how long? **_____**

Have you ever smoked, vaped or chewed tobacco? Yes / No
If yes, for how long?_____

Have you ever sought professional care or been hospitalized for:
Substance abuse Yes / No
Emotional disorders Yes / No
Alcoholism Yes / No

Do you use:
Alcohol? Yes / No If yes, how often per week?_____
Marijuana? Yes / No If yes, how often per week?_____
Recreational drugs? Yes / No If yes, how often per week?_____

HEALTH HISTORY FORM

Patient's Name _____

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