ORAL & MAXILLOFACIAL SURGERY OF FAIRFIELD COUNTY

HEALTH HISTORY

Name: _____ Age: _____

Height: _____ Weight: _____

Have you had or do you currently have any of the following conditions (CIRCLE those that apply):

	Yes	No		Yes	No
Heart valve surgery/murmur/ condition	( )	( )	Irregular heartbeat? pacemaker/defribillator	( )	( )
History of rheumatic fever	( )	( )	Atrial Fibrillation, Heart block, palpitations	( )	( )
Coronary artery disease/ Stents	( )	( )	Heart failure/disease, Heart/Bypass surgery	( )	( )
Chest pain or Angina	( )	( )	Kidney or bladder condition (Nephritis)	( )	( )
Heart attack or Stroke, TIA history	( )	( )	Dialysis, Kidney condition or failure	( )	( )
High or Low blood pressure	( )	( )	Diabetes or low blood sugar	( )	( )
History of Head Injury or concussion	( )	( )	IBD, inflammatory bowel disease	( )	( )
Thyroid condition	( )	( )	Ulcerative Colitis or Crohn's disease	( )	( )
History of Headaches or Migraines	( )	( )	Rheumatoid Arthritis, Lupus, Scleroderma	( )	( )
Ulcer, Reflux, gastritis, esophagitis	( )	( )	Hepatitis, Jaundice or Liver condition	( )	( )
Pneumonia, bronchitis, cough	( )	( )	History of Blood transfusions	( )	( )
Asthma, Eczema, Allergic Rhinitis	( )	( )	Blood disorder / Anemia	( )	( )
Sinusitis / Nasal Problems	( )	( )	Do you bruise easily Nosebleeds	( )	( )
Snoring or Sleep apnea, CPAP	( )	( )	Bleeding tendency / Hemophilia	( )	( )
Difficulty breathing or short of breath	( )	( )	Gall bladder trouble/surgery	( )	( )
Tuberculosis	( )	( )	Vertigo, Dizziness, Tinnitus, hear ringing	( )	( )
COPD or Emphysema	( )	( )	Osteoarthritis/other joint condition (Gout)	( )	( )
Do you SMOKE Or Chew tobacco	( )	( )	Osteoporosis / Osteopenia	( )	( )
Recreational/Illicit drug use/abuse	( )	( )	Malignant Hyperthermia	( )	( )
Enzyme deficiency	( )	( )	History of MRSA infection	( )	( )
Immuno-suppressed/ compromised	( )	( )	Sexually Transmitted diseases, or HIV	( )	( )
Infectious disease, Transplant	( )	( )	Autism, Autism spectrum, Tourettes	( )	( )
CHRONIC PAIN management	( )	( )	Developmental delay	( )	( )
Delay in wound healing	( )	( )	Anxiety, Depression, ADD/ADHD,	( )	( )
Chronic fatigue / night sweats	( )	( )	Schizophrenia, Bipolar or Mood disorder	( )	( )
Epilepsy or seizures	( )	( )	Alcohol Abuse/Dependency	( )	( )
Insomnia / Narcolepsy	( )	( )	Medication or Drug Abuse/Dependency	( )	( )
Cancer, chemotherapy, radiation	( )	( )	Spine or Back injury or surgery	( )	( )
Fainting or Syncope	( )	( )	Sensitive Gag Reflex, History of Nausea	( )	( )
Gastric Bypass surgery	( )	( )	Orthopedic/ ***joint replacement*** **surgery**	( )	( )
Numbness, Weakness	( )	( )	Previous Jaw/Facial fractures or surgery	( )	( )

	Yes	No
Reason for today's Visit _____		
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 problem with any type of anesthesia in the past?	( )	( )
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, or grinding or clenching, or difficulty opening your	( )	( )
mouth? Do you need rest of 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 being 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?	( )	( )
Biphosponates? (Aredia, Zometa, Fosamax, Actonel, Reclast, Boniva, Xegva, Prolia)	( )	( )
Blood thinner medications? (Aspirin, Coumadin, Plavix, Pradaxa, Xarelto, Aggrastat, Persantine)	( )	( )
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: _____