Midwest Oral & Craniofacial Specialists

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 care.
Please speak with the doctor or staff if there are any questions about this form.

MEDICAL HISTORY

Please describe your current overall health: Excellent Good Fair Poor

Have there been any changes in your general health in the past year? Yes / No
If yes, please describe: _____

Are you now under a doctor's care for a medical condition? 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? Yes / No
If yes, please describe_____
_____

Have you ever had surgery? Yes / No
If yes, please describe_____
_____

Do you have, or have you ever had, any of the following conditions:

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: _____

Patient's Name _____ Today's Date _____

Do you have any other medical conditions that are important for your doctor to know about? Yes / No
If yes, please describe: _____
_____

FAMILY MEDICAL HISTORY - Do you have a family history of any of the following conditions?

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 anesthesia, general anesthesia, and/or intravenous sedation? Yes / No If yes, please describe_____

ALLERGIES – Are you allergic to or have you had an adverse reaction to:

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? If yes, please describe: _____ _____	Yes / No

ANESTHESIA HISTORY

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

FEMALE PATIENTS

Are you pregnant? Yes / No Is there any chance you might be pregnant? Yes / No

DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? Yes / No

SOCIAL HISTORY

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?_____

Patient's Name _____ Today's Date _____

MEDICATIONS – Are you currently prescribed or taking any of the following:

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	Any other medications or supplements?	Yes / No

MEDICATIONS (continued): Please list the specific medications indicated above and/or any other medications not listed above that you are currently taking. Please including all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

Medication and dose	**Medication and dose**

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.

_____

Patient Signature OR Signature of Guardian/Responsible Party Date

_____

Patient Printed Name (AND Printed Name of Patient's Legal Representative if Applicable)

Patient's Name _____ Today's Date _____

For office staff use - HEALTH HISTORY REVIEW

Date	Comments	Doctor's Signature

For office staff use - ADDITIONAL CLINICAL DOCUMENTATION

Patient's Name _____ Today's Date _____

For Oral Surgery Patients ONLY

DENTAL HISTORY

Please describe your current dental health: 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? Yes / No
If yes, please describe_____

Are you having any dental discomfort at this time? Yes / No
If yes, please describe_____

Have you had any adverse effects from dental treatment? 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:

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		