## Center for Oral Facial & Implant Surgery Associates in Oral & Maxillofacial Surgery, P.C.

## HEALTH HISTORY

**To our patients:** Although oral and maxillofacial surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Patient Name:	Weight:
Date of Birth:	 Height:

Reason for visit:

Prior Surgeries/Hospitalizations	Medications (Prescribed/O	Allergies (Food and Drug)	
	NAME C	DOSE FREQUENCY	REACTIONS
	<ul><li>Taking diet drugs/medications</li><li>Taking blood thinner</li></ul>		Latex allergy

<u>Anesthesia</u>	Re	ated	Info	rma	<u>ation</u>	
1				1		

Have you ever had general anesthesia? □No □Yes Complications with anesthesia: □No □Yes, reaction:\_\_\_\_\_ History of malignant hyperthermia: □No □Yes Family history of malignant hyperthermia: □No □Yes Family history of complications with anesthesia: □No □Yes, reaction:\_\_\_\_\_

Social History         Alcohol Use:       □Not at all       □Daily       □Weekly Monthly         Substance/IV Drug use:       □Current, type:         Smoking status:       □Current       □Former       □Never         Chewing tobacco use:       □Current       □Former       □Never	_ □Former. type: _ Packs/day			_
For WomenAre you currently pregnant?□No□YesPost Menopause/Hysterectomy?□No□YesBirth control method:□None□Type,	Nursing?	□No	□Yes	

## Please check any of the conditions below which you have been diagnosed

Neurological			Cardiovascular			
<ul> <li>Migraines</li> <li>Seizures</li> <li>Fainting Spells</li> <li>Developmental Delay</li> <li>Stroke, Date</li> <li>Parkinson's</li> </ul> Psycho Anxiety Disorder Depression	<ul><li>Dementia</li><li>TIA</li><li>Tremors</li></ul>	<ul> <li>High Blood Pressure</li> <li>High Cholesterol</li> <li>Coronary Artery Disease</li> <li>Congestive Heart Failure</li> <li>Irregular Heart Beat Type:</li> <li>Mitral Value Prolapse</li> <li>Blood Clots (Legs, Lungs)</li> <li>Other not listed:</li></ul>	<ul> <li>Artificial Heart Value</li> <li>CABG, other surgery:</li> </ul>			
Depression			Respiratory			
Endo Diabetes (Insulin) Last AIC Thyroid Disorder Gastroir GERD/ Acid Reflux	<ul> <li>Diabetes (Non-Insulin) Last AIC</li> <li>Adrenal Insufficiency</li> </ul>	<ul> <li>Emphysema</li> <li>COPD</li> <li>Asthma</li> <li>Smoker</li> <li>Vape Use</li> <li>Marijuana Use</li> <li>Tubercucosis (TB)</li> </ul>	<ul> <li>Obstructive Sleep Apnea</li> <li>CPAP Use</li> <li>COVID with hospitalization</li> <li>Shortness of breath at rest</li> <li>Recent respiratory infection</li> <li>Recurrent respiratory infection</li> <li>Oxygen use at home</li> </ul>			
Gastroparesis	Liver Disease	Musculoskeletal				
<ul> <li>Inflammatory Bowel Dise.</li> <li>Eye Disease</li> <li>Glaucoma</li> <li>Sinus Surgery</li> <li>Facial Surgery</li> <li>Oral Cancer</li> <li>Radiation to face or neck</li> </ul>	NT <ul> <li>Herpes simplex type 1 (Cold Sores)</li> <li>Unhealed mouth sores</li> <li>Pain/Clicking of jaw</li> <li>Throat Cancer</li> </ul>	<ul> <li>Osteoporosis</li> <li>Osteopenia</li> <li>Rheumatoid Arthritis</li> <li>Arthritis</li> <li>Osteonecrosis</li> <li>Fibromyalgia</li> <li>Joint Replacement</li> </ul>	<ul> <li>Cervical Fusion</li> <li>Other spinal Surgery:</li> <li>Bisphosphonate Use ex: Fosomax, IV Zometa, Prolia, Xgeva, Reclast</li> <li>Medication:</li> <li>Years of use:</li> <li>Frequency:</li> <li>Current </li> <li>Former</li> </ul>			
Kidney Disorder			Hematology			
If checked, please specify Dialysis, schedule		<ul> <li>Anemia</li> <li>Blood Disorder Type:</li> </ul>	<ul> <li>□ HIV/AIDS</li> <li>□ Blood Transfusion Year:</li> <li>□ Sickle Cell Disease</li> <li>□ Bleeding Issues</li> </ul>			
<ul> <li>Other problem with immu</li> <li>Specify:</li> <li>Autoimmune Disorder</li> </ul>	ine system	Cancer, type:	Surgery D Radiation D Chemotherapy			
<ul> <li>Autoimmune Disorder</li> <li>Specify:</li> <li>History of Rheumatic Fev</li> <li>Delay in healing</li> </ul>	/er	Any other condition concer	ning your health, please list:			
	d and I understand the question I have made in the completion		r any other member of his / her staff, responsible for any			
X Signature of patient (	Parent or Guardian if Minor)	Date X Reviewed b	y X Date			
PIF-HH						