Health History (ALL RESPONSES ARE KEPT CONFIDENTAIL)

Patient Sticker

TOP SECTION OFFICE USE ONLY:

BP_____ Age_____ Pulse_____ Height_____ Weight_____ BMI_____

Pre op Instructions_____ Op-Consent_____ Chart Review_____ Video Watched here_____ At Home_____

*Please answer all questions

1. Are you in good health Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam_____
4. Are you now under a physician's care or a particular problem Y N
5. Have you ever had any serious illnesses, operations or hospitalizations?
If so please describe:

_____

_____

_____

6. **Are you allergic or have you had an adverse reaction to:**

Local Anesthesia (Novocain etc….)	Y	N
Penicillin or other antibiotics	Y	N
Sedatives or barbiturates	Y	N
Aspirin or Ibuprofen	Y	N
Codeine or other pain killers	Y	N
Latex or rubber gloves	Y	N
Other allergies or reactions	Y	N

Please List:

_____

7. Do you take or have you ever taken any bisphosphonates:
Editronate (didronel), Tiludronate (Skelid), Alendronate (Fosamax), Risedronate (Actonel), Ibandronate (Boniva), Pamidronate (Aredia), Zoledronate (Zometa),Zoledronic acid (Reclast), Denosumab (Prolia), Bevacizumab (Avastin) Y N

8. Do you smoke or chew tobacco Y N
If so, how much per day _____
9. Is there any past history of alcohol or chemical Dependency or emotional disorders that may effect the care we provide Y N
10. Have you or any immediate family member had any problem associated with intravenous anesthesia ? Y N
11. Do you have any other disease, condition or problem not listed above that the doctor should know about? Y N
12. Do you wish to talk to the doctor privately about anything? Y N

Signature of Patient **Date**

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor.

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Do you have or have you ever had:

Heart (Surgery, disease, attack, Pacemaker)	Y	N
High Blood Pressure	Y	N
Chest Pain	Y	N
Heart Murmur	Y	N
Mitral Valve Prolapse	Y	N
Rheumatic Fever	Y	N
Swollen Ankles	Y	N
Active Tuberculosis	Y	N
Prolonged Cough 3-4 weeks	Y	N
Bloody Cough	Y	N
Unexplained weight loss	Y	N
Night sweats	Y	N
Emphysema	Y	N
Other respiratory illness	Y	N
Asthma	Y	N
Seizures, Epilepsy, or Convulsions	Y	N
Fainting or Dizziness	Y	N
Bleeding disorder, Anemia, Bleeding tendency or Blood transfusion	Y	N
Do you bruise easily	Y	N
Liver Disease (Jaundice, Hepatitis)	Y	N
Kidney Disease	Y	N
Diabetes	Y	N
Thyroid Disease (Goiter)	Y	N
Arthritis	Y	N
Glaucoma	Y	N
Implants Placed anywhere in your body	Y	N
Radiation (X-Ray) treatment for Cancer	Y	N
Jaw Pain or clicking, popping, difficulty Difficulty opening, grinding, clenching teeth	Y	N
Sinus or nasal problems	Y	N
Any disease, drug, or transplant operation that has depressed your immune system	Y	N
Syphilis	Y	N
Venereal Disease	Y	N
Herpes	Y	N
AIDS	Y	N
Cold Sores/Fever blisters	Y	N

FOR WOMEN ONLY:

Are you pregnant, or is there a chance you might be Y N

If you are using ORAL CONTRACEPTIVES, it is important that you understand that antibiotics and some other medications, may interfere with the effectiveness of oral contraceptives, Therefore you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of the antibiotics or other medications is completed Please consult with your physician if further guidance is needed.

_____ Patient's initials.

Are you on Depo-Provera Injections? Y N

St. Augustine Oral and Facial Surgical Center

Medication Reconciliation Record

Please list all prescriptions, over the counter, vitamins, and herbal/natural medications that you are currently taking.

(Last two columns to be completed by Dr Johnson)

Medication:	Dose:	How often:	Route:	Hold	Resume