ORAL & MAXILLOFACIAL SURGERY
HEALTH HISTORY for Hennig, Woodbury & Howard PC

NAME: _____ DATE: _____ REFERRED BY: _____

Reason for your visit: _____

Height: _____ Weight: _____ Age: _____ any recent changes in your general health? Yes No

List any medical conditions that we should be aware of: _____

Have you been under the care of a physician in the past year? Yes No
If "yes", for what purpose? _____

Please indicate all past surgery _____

Are you now taking ANY kind of medicine, drug or pill for any purpose? Yes No
If "yes", please list (include herbal meds) _____
_____

Are you allergic or have you had a reaction to any drugs or medications? Yes No
If "yes", please list _____

Are you allergic to *Latex?* **Yes** **No** **Are you allergic to *Eggs, Soy and/or Peanuts*?** **Yes** **No**

Have you had or do you currently have any of the following? Please circle yes or no.

Rheumatic fever	yes	no	Bronchitis, chronic cough	yes	no	Artificial joints	yes	no
Heart problems	yes	no	Asthma	yes	no	Anemia	yes	no
Heart attack	yes	no	Tuberculosis	yes	no	Diabetes	yes	no
Heart surgeries	yes	no	Emphysema	yes	no	Cortisone use	yes	no
Heart murmur	yes	no	Difficulty breathing	yes	no	Steroid use	yes	no
Artificial / human valves	yes	no	Malignant hyperthermia	yes	no	Stomach ulcers	yes	no
Chest pain, angina	yes	no	Other lung trouble	yes	no	Radiation treatment	yes	no
Irregular heart beat	yes	no	Sinus problems	yes	no	Chemotherapy	yes	no
Mitral valve prolapse	yes	no	Fainting tendency	yes	no	Bleeding problems	yes	no
Pacemaker	yes	no	Hepatitis or liver disease	yes	no	Bruise easily	yes	no
Stroke	yes	no	Painful jaw joints	yes	no	Taking a blood thinner	yes	no
High blood pressure	yes	no	TMJ problems	yes	no	Problems healing	yes	no
Low blood pressure	yes	no	Seizures/epilepsy	yes	no	Kidney disease	yes	no
Thyroid disease	yes	no	HIV	yes	no			

Chewing tobacco yes no Do you smoke yes no How much? _____ Alcoholic drinks per week _____

Have you ever had IV bisphosphonate chemotherapy drugs such as Zometa or Aredia? yes no

Have you ever, or are you, taking any of the specific following medications below?: yes no

If "yes", please circle those that apply: **Fosamax, Actonel, Boniva, Reclast, Prolia or Xgeva**

Do you have any oral abnormalities	yes	no
Prior orthodontic treatment (braces)	yes	no
Prior surgical removal of teeth	yes	no
Prior gum disease treatment	yes	no
Prior facial injury or facial surgery	yes	no
Pre-existing nerve damage to face	yes	no

Do you take antibiotics before cleanings: yes no
Your last dental visit/cleaning _____

WOMEN:
Any chance that you may be pregnant yes no
Are you taking birth control pills yes no

I HAVE READ AND UNDERSTAND THE FORM ABOVE AND HAVE ANSWERED TO THE BEST OF MY ABILITY

Signature _____ Doctor's Initials _____