Gulf Coast Oral and Facial Surgery
Health History

1. Are you in good health? Y N Height ________ Weight ________
2. Are you now under a physician's care? Physician's name & last exam date____________________ Y N
3. Are you currently under ***pain management***? Physician's name ______________________________ Y N
4. Are you taking medication(s) including ***pain medicine*** and nonprescriptions? Y N
   List____
5. Are you currently taking ***anticoagulants/blood thinners***? List ______________________________
6. Have you had any serious illnesses, surgeries, or hospitalizations? Y N
   Explain: ____
7. Are you allergic to or had reaction to:
   - **Local anesthetic (novocaine, etc.)** Y N
   - **Antibiotics (penicillin, etc.** Y N
   - **Pain Medicine or sedatives** Y N
   - **Latex** Y N
   - **List other allergies**____ Y N
8. Do you have sleep apnea? Y N
   Do you sleep with a cpap or bipap machine? Y N
9. Have you had any adverse effects from dental treatment? Y N
10. Do you smoke, dip or chew tobacco? **If yes, how long**_____________________________________ Y N
11. Have you ever sought professional care for drug abuse, alcoholism or emotional disorders? Y N
12. Have you or your family had any previous problems with anesthesia/sedation? Y N
13. Are you now or have you ever taken any of the following medications for osteoporosis?
    Oral Bisphosphonates: Fosamax, Actonel, Didronel, Boniva Y N
    IV Bisphosphonates: Aredia, Zometa, Reclast Y N
14. Have you had a previous history of temporomandibular joint disease (TMJ) ? Y N
15. Do you have or have you had: (Please check **YES** or **NO** on **EACH line.**)

	YES	NO
HEART DISEASE		
*Rheumatic Fever		
*Rheumatic Heart Disease		
*Heart Murmur		
*Mitral Valve Prolapse		
High Blood Pressure		
Angina		
Heart Attack (Coronary)		
*Heart Defects		
Stroke		
Abnormal Electrocardiogram (EKG)		
Heart Surgery		
*Pacemaker		
LUNG DISEASE	YES	NO
Bronchitis		
Asthma		

	YES	NO
LIVER DISEASE		
Hepatitis		
Cirrhosis		
DIABETES (Sugar)		
Do You Take Insulin?		
THYROID DISEASE		
GLAUCOMA		
SEIZURE DISORDER		
BLEEDING PROBLEMS		
ANEMIA		
AIDS or HIV Positive		
SICKLE CELL ANEMIA or TRAIT		
TUMOR or CANCER		
RADIATION (Cobalt) THERAPY		
*HIP JOINT SURGER		
NEUROLOGICAL DISORDER		

16. Women: Are you pregnant? Y N
    Are you taking birth control pills? Y N
    Are you taking hormone replacements? Y N
    Do you have an implanted birth control device in your upper arm? Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

____/__________________

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY DATE DR's. INITIALS