HEALTH HISTORY **PATIENT NAME:** _____

To Our Patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication 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.

Reason for today's office visit: _____

	Yes	No
1. Are you in good health? Height Weight		
2. Have there been any changes in your health in the past year?		
3. Are you under the care of a physician? Date of last visit: _____ *If so, for what are you being treated?*		
4. Have you had any illness, operation or been hospitalized in the past five years? *If so, describe.*		
5. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? *If so, describe where.*		
6. Do you have a prosthetic joint/implant? *If so, describe where.*		
7. Have you had a heart valve replacement or vascular graft?		

Have you had or do you currently have…	Yes	No	Notes	Have you had or do you currently have…	Yes	No	Notes
8. Rheumatic fever?				31. Hepatitis, jaundice, or liver disease?			
9. Damaged heart valves/ mitral valve prolapse				32. Infectious mononucleosis?			
10. Heart Murmur?				33. Gallbladder trouble?			
11. High Blood Pressure?				34. Fainting spells or syncopal episodes?			
12.Low Blood Pressure?				35. Convulsions/epilepsy?			
13. Chest Pain/ angina?				36. Stroke?			
14. Heart Attacks?				37. Thyroid Trouble?			
15. Irregular heart beat?				38. Diabetes?			
16. Cardiac Pacemaker?				39. Low Blood Sugar?			
17.Heart Surgery?				40. Kidney Trouble?			
18. Bronchitis/ chronic cough?				41. Are you on dialysis?			
19. Asthma, reactive airway disease?				42. Swollen ankles, arthritis or joint disease?			
20. Hay Fever/ sinus problems				43. Stomach ulcers?			
21. Snoring/ Sleep apnea?				44. Contagious diseases?			
22. Difficulty Breathing/ other lung trouble?				45. HIV/AIDS			
23. Tuberculosis?				46. Sexually transmitted disease?			
24. Emphysema?				47. Problems with the immune system?			
25. Do you smoke?				48. Delay in healing?			
26. Do you use chewing tobacco?				49. A tumor or growth?			
27. Blood Transfusion?				50. Radiation therapy/ chemotherapy?			
28. Blood disorder such as Anemia?				51. Chronic fatigue/ night sweats			
29. Bruise easily?				52. Are you on a diet?			
30. Bleeding tendency?				53. History of drug abuse?			

continued… Have you had or do you currently have…	Yes	No	Notes
54. History of alcohol abuse?			
55. Contact lenses?			
56. Eye disease/ glaucoma?			
57. Mental Health problems?			
58. A removable dental appliance?			
59. Pain and clicking of the jaws when eating?			
60. Malignant hyperthermia?			
61. Problems with General Anesthesia?			

MEDICATION Are you now taking…	Yes	No	Notes
62. Any kinds of medication, drugs or pills?			
63. Blood thinners? (Coumadin, Aspirin, Advil)			
64. Have you ever taken diet pills?			
65. Tranquilizers?			
66. Any natural product, herbal supplement or homeopathic remedy?			

ALLERGIES Are you allergic to or had a reaction to…	Yes	No	Notes
68. Local Anesthetic? (numbing medication?)			
69. Penicillin?			
70. Other Antibiotics?			
71. Sulfa Drugs?			
72. Sodium pentothal, Valium or other tranquilizers?			
73. Aspirin?			
74. Codeine or other narcotics?			
75. Latex?			
76. Other Medications?			
77. Soy?			
78. Eggs/ yolk?			
79. Sulfites?			
Please list any allergies other than drug allergies below…			

_____

_____

_____

67. Please list any medications you are taking…

_____

_____

Is there any condition concerning your health that the doctor should be told about?
☐ Yes ☐ No *(if so, describe)* _____

Is there a **family history** of:
Cancer: ☐ Yes ☐ No
Diabetes: ☐ Yes ☐ No
Heart Disease: ☐ Yes ☐ No
Anesthetic Problems? ☐ Yes ☐ No

Is this visit related to an accident? ☐ Yes ☐ No
Date of Injury:_____

In case of EMERGENCY contact:
Name:
Home Tel. ( )
Bus. Tel. ( )

This section is for women only.

Is there a possibility of pregnancy? ☐ Yes ☐ No
Expected delivery date: ___/___/___.
Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No
*Antibiotics may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

AUTHORIZATION

PATIENT NAME: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my oral surgeon, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. I understand the importance of a truthful health history to assist the doctor in providing the best care possible.

I authorize Dr. Gaines and his designated staff to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Signature of Patient: (Parent or guardian if minor) **X** _____ **Date: X** _____

FEES AND PAYMENT

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or your surgery you may require will be given to you upon request. If you have any dental and / or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys' fees and court costs.

Signature of Patient: (Parent or guardian if minor) **X** _____ **Date: X** _____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Roy E. Gaines, Jr., D.D.S., M.D., P.A. of the benefits otherwise payable to me.

Signature of Patient: (Parent or guardian if minor) **X** _____ **Date: X** _____