Turlock
Oral & Maxillofacial Surgery

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Phone: (209) 667-5050

We thank you for completing this record accurately. Please feel free to ask for assistance if necessary. As with all information contained in your chart, this document is confidential.

Name: ______________________ Date: ______________________

Date of Birth: ____________ Age: ____________ Occupation: ____________________

Male ☐ Female ☐

HEALTH HISTORY

1. **General Health**: ☐ Good ☐ Fair ☐ Poor — YES NO
2. Are you now or have you been under a physician's care during the past 5 years? _____ ☐ ☐
   What for? ______________________
3. Are you currently under a doctor's orders? What orders? ______________________ ☐ ☐
   ____
4. Have you ever had a serious illness? What? ______________________ ☐ ☐
   ____
5. Have you had or are you currently having multiple headaches? ______________ ☐ ☐
   a. How frequent? ___________ What causes it? ______________
6. Have you had or are you currently having neck pain? ______________________ ☐ ☐
   a. How frequent? ___________ What causes it? ______________
7. Have you had previous surgeries? What? Age? ☐ ☐
   1. ______________________ _____
   2. ______________________ _____
   3. ______________________ _____
   4. ______________________ _____
   5. ______________________ _____
8. Have you ever had a general anesthetic? (put to sleep for surgery) ______________ ☐ ☐
9. Do you have Sleep Apnea or do you severely snore? ______________________ ☐ ☐
10. Have you or anyone in your family had complications with general anesthesia? ______ ☐ ☐
11. Do you have Diabetes? ______________________ ☐ ☐
12. Have you ever taken a prescription diet medication such as Fen-Phen, or Redux? _____ ☐ ☐
13. Have you ever or are you currently taking a Bisphosphonates? ______________ ☐ ☐
    a. How recently? ______________ For how long? ______________
14. Do you have Osteoporosis or bone cancer? ______________________ ☐ ☐

NEUROLOGIC

Dementia ______________________ YES _______ NO _________
Alzheimer ______________________ YES _______ NO _________
Parkinson's Disease ______________________ YES _______ NO _________
Epilepsy ______________________ YES _______ NO _________

MEDICATIONS

15. List all Prescription and NON-Prescription drugs, including Aspirin, Tylenol, Advil, etc.

	DOSE	Times When Taken
A		
B		
C		
D		
E		

20. Have you had any of the following?

	YES	NO	IF YES, WHEN WAS THIS?
HEART DISEASE			
Rheumatic Fever ____	☐	☐	____
Heart Murmur ____	☐	☐	____
High Blood Pressure ____	☐	☐	____
Angina ____	☐	☐	____
Heart Attack (Coronary) ____	☐	☐	____
Abnormal Electrocardiogram (EKG) ____	☐	☐	____
Heart Surgery ____	☐	☐	What? ____
Valve replacement? yes ☐ no ☐			
Pacemaker ____	☐	☐	____
Chest Pain ____	☐	☐	____
Swollen Ankles ____	☐	☐	____
Mitral Valve Prolapse ____	☐	☐	____
Stroke ____	☐	☐	____
LUNG DISEASE			
Bronchitis ____	☐	☐	____
Asthma ____	☐	☐	____
If yes:			
Does aspirin make your asthma worse? ____	☐	☐	____
Have you ever gone to the emergency room or been admitted to the hospital because of asthma? ____	☐	☐	____
Do you use an inhaler? ____	☐	☐	____
Do you use a peak flow meter? ____	☐	☐	____
(If so, bring this as well as any inhalers you use with you on the day of surgery.)			
Emphysema ____	☐	☐	____
Tuberculosis ____	☐	☐	____
Shortness of breath ____	☐	☐	____
EYE DISEASE			
Glaucoma ____	☐	☐	Any medication? ____
KIDNEY DISEASE ____	☐	☐	____
GASTRIC (STOMACH) ULCER ____	☐	☐	When? ____
LIVER DISEASE ____	☐	☐	____
Hepatitis (Yellow Jaundice) ____	☐	☐	____
Cirrhosis ____	☐	☐	____
TUMOR OR CANCER ____	☐	☐	____
Radiation Therapy ____	☐	☐	____
Chemotherapy ____	☐	☐	____
Immune System Disease ____	☐	☐	____
HERPES ____	☐	☐	____
JOINT DISEASE			
HIP JOINT SURGERY ____	☐	☐	____
Do you have ANY implanted metal joints? ____	☐	☐	____
Other joint surgery ____	☐	☐	____
Arthritis ____	☐	☐	____
Within the last **six** months, or **currently**, are you taking?			
a. Blood Thinners ____	☐	☐	____
b. Cortisone (Steroids) ____	☐	☐	____

	YES	NO
21. Do you smoke or use any tobacco products? How much? ____________	☐	☐
22. Do you consume alcohol? How much? ____________	☐	☐
23. Do you or have you used illicit drugs? What? ____________	☐	☐
24. Have you had seizures? ____________	☐	☐
25. Have you had fainting spells? ____________	☐	☐
26. Do you wear contact lenses? ____________	☐	☐
27. Do you wish to speak privately with the doctor about anything? ____________	☐	☐

28. Height ____________ Weight ____________

FOR WOMEN ONLY	**YES**	**NO**
16. Are you using an oral contraceptive?____________		
17. Are you pregnant? Due Date? ____________		
18. Are you trying to become pregnant at this time? ____________		
19. Are you aware that an antibiotic may interfere with the function of birth control pills?		

Are You Allergic To:	**YES**	**NO**
Penicillin ____________	☐	☐
Demerol ____________	☐	☐
Novacaine ____________	☐	☐
Codeine ____________	☐	☐
Aspirin ____________	☐	☐
Barbiturates ____________	☐	☐
Other Drugs ____________	☐	☐
Latex ____________	☐	☐
Soy/Eggs ____________	☐	☐

Name of my Physician ____________

Name of my Dentist ____________

I was referred by ____________

I confirm as true the above Health History Information

Signature ____________ Date ____________

Parent or Guardian ____________ Date ____________

OFFICE USE ONLY This Health History Re-read and Reconfirmed in its entirety and all additions or corrections noted by patient, parent or guardian:

HEALTH UPDATES

	Date	Signed
Green	____________	____________
Blue	____________	____________

ASA Classification

I **II** **III**

Dr. ________ DATE: ________

Misc. Information

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