Health History

Intake Vitals	
Blood Pressure:	_____ / _____ mmHg
Pulse:	_____ bpm
SpO_2:	_____ %

ORAL SURGEONS of SANTA ROSA

Patient Name: _____ Gender: _____ Height: _____ Weight: _____

1. Please list <u>all past and present</u> medical conditions and years diagnosed (additional space on back of form): _____

_____

_____

2. Who is your physician? _____ Phone: _____
   Who is your dentist? _____ Phone: _____
3. Have you ever been hospitalized? ◯ Yes ◯ No
   If yes, please list illness and year: _____
4. Do you have or have had any of the following conditions?

Heart Disease	☐ Yes	☐ No	High or Low Blood Pressure	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Radiation or Chemotherapy	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Fever following anesthesia or exercise	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Muscular Disorders	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Blood Transfusions	☐ Yes	☐ No
Pre Diabetes	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
AIDS or HIV	☐ Yes	☐ No	Bloody Urine	☐ Yes	☐ No
Prosthetic Joints	☐ Yes	☐ No	Organ Transplant	☐ Yes	☐ No
Alcohol Abuse	☐ Yes	☐ No	Blood Clots in the legs or lungs	☐ Yes	☐ No
Substance Abuse	☐ Yes	☐ No			

5. Are you currently taking any drugs or medications? ☐ Yes ☐ No
   If yes, please list (additional space on back of form): _____
6. Are you allergic or sensitive to any medications or products? ☐ Yes ☐ No
   If yes, please list (additional space on back of form): _____
7. Do you have a history of breast, bone, prostate, lung, or metastatic cancer? ☐ Yes ☐ No
8. Have you ever received injection-based bone strengthening medicine (Reclast/Prolia/Xgeva/Zometa)? ☐ Yes ☐ No
9. Have you ever taken oral bisphosphonates? ☐ Yes ☐ No
10. Are you being treated for osteoporosis? ☐ Yes ☐ No
11. Do you bleed excessively when injured or after surgery? ☐ Yes ☐ No
12. Are you subject to fainting, lightheadedness, or anxiety while receiving medical care? ☐ Yes ☐ No
13. Do you snore or have you ever received a diagnosis of sleep apnea? ☐ Yes ☐ No
14. Do you have difficulty breathing or have ever received a diagnosis of asthma, COPD, tuberculosis, etc? ☐ Yes ☐ No
15. Have you ever had an adverse reaction to dental local anesthetic? ☐ Yes ☐ No
16. Do you or your genetic family have any known relatives who have been diagnosed with malignant hyperthermia? ☐ Yes ☐ No
17. Have you ever had an adverse reaction to intravenous sedation or general anesthesia? ☐ Yes ☐ No
18. Do you smoke? ☐ Yes ☐ No
    If yes, what product and how often: _____
19. Have you used any recreational drugs (cocaine, methamphetamine, heroin, etc) within the past year? ☐ Yes ☐ No
    If yes, which substance? (*truthful answers are lifesaving and will be kept private*) _____

<u>For women:</u>

20. Are you pregnant? ☐ Yes ☐ No
21. Are you currently breastfeeding? ☐ Yes ☐ No
22. Are you taking oral contraceptive pills (birth control)? ☐ Yes ☐ No

I attest that the above information is true and correct to my knowledge.
I am aware that failure to disclose accurate information places me and my health at serious risk.

Signature of Patient or Parent/Guardian: _____ Date: _____

Health History

If there was insufficient room on the previous page, please place the information below

Patient Name: _____

Medical Problems

Medications

Allergies

Other Comments