DR. JEREMY KING, DMD, FRCD(C)

ORAL AND MAXILLOFACIAL SURGERY

CONFIDENTIAL HEALTH HISTORY

The following information is requested to help the Oral Surgeon make a thorough diagnosis.
Also, we strive to be considerate of your time and feelings. Thank you for your cooperation.

Patients Name_____ Date_____

Address_____ Home Phone_____

City & Postal Code_____ Cell Number_____

Email_____ Work_____

Birth Date (DD/MM/YYYY)_____ Age_____

1. Care Card Number: _____ First Nation #:_____

2. Personal physician/family doctor_____ Phone_____

Last visit?_____ For what purpose?_____

Preferred Pharmacy _____ Phone_____

3. Have you had any serious illness? If so, what and when?_____

4. Are you now under a physician's care for a particular problem? _____

5. Would you estimate your present health as: poor fair good excellent **(circle one)**

6. Do you have or have you ever had? **(Circle yes or no)**

	Y	N
A. Rheumatic Fever or Rheumatic Heart Disease?	☐	☐
B. Congenital Heart Disease?	☐	☐
C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpations, Heart Surgery, Pacemaker)?	☐	☐
D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?	☐	☐
E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?	☐	☐
F. Bleeding disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?	☐	☐
G. Liver Disease (Jaundice, Hepatitis: A, B or C)?	☐	☐
H. Diabetes: Type: 1 or 2 (circle one)	☐	☐
I. Thyroid Disease (Goiter)?	☐	☐
J. Arthritis?	☐	☐
K. Stomach Ulcers or Colitis?	☐	☐
L. Glaucoma?	☐	☐
M. Osteoporosis?	☐	☐
N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?	☐	☐
O. Radiation (x-ray) treatment for Cancer?	☐	☐
P. HIV or AIDS (circle one)	☐	☐
Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?	☐	☐
R. Sinus or Nasal Problems?	☐	☐
S. Any disease, drug or transplant operation that has depressed your immune system?	☐	☐

7. Are you using any of the following?

A. Antibiotics?	☐	☐
B. Anticoagulants (Blood Thinners)?	☐	☐
C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	☐	☐
D. High Blood Pressure medication?	☐	☐
E. Steroids (Cortisone, Prednisone, etc)?	☐	☐
F. Tranquilizers?	☐	☐
G. Insulin or Oral Anti-Diabetic drugs?	☐	☐
H. Digitalis, Inderal, Nitroglycerin, or other heart drug?	☐	☐

(Continue On Other Side) →

I. Are you taking or have you ever taken *Bisphosphonates* for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)? Y ☐ N ☐

J. Please List any and all medications taken regularly; including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:

_____

_____

_____

_____

8. Are you allergic to or have you had an adverse reaction to:

	Y	N
A. Local Anesthesia (Novacain, etc)?	☐	☐
B. Penicillin or other antibiotics?	☐	☐
C. Sedatives, Barbiturates?	☐	☐
D. Aspirin or Ibuprofen?	☐	☐
E. Codeine or other pain killers?	☐	☐
F. Latex or Rubber products?	☐	☐
G. Metal of any kind?	☐	☐
H. Chemicals or jewelry (rash or sensitivity)?	☐	☐
I. Food Products?	☐	☐
J. Other allergies/reactions? Or advised not to take a medication? Please list	☐	☐

_____

_____

_____

Dental Insurance: ☐ ☐

Ins. Company _____

Group # _____ **ID#** _____

	Y	N
9. Do you smoke or chew tobacco? History of Smoking if yes how many per day? _____	☐	☐
10. Is there any past history or Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?	☐	☐
11. Have you had any serious problems associated with any previous dental treatment?	☐	☐
12. Have you an immediate family member had any problem associated with intravenous anesthesia?	☐	☐
13. Do you have any other disease, conditions or problem not listed above that you think the doctor should know about?	☐	☐
14. Do you wish to talk to the doctor privately about anything?	☐	☐
15. Have you ever had a bone density scan?	☐	☐

16. ***Women Only***

	Y	N
A. Are you pregnant, or is there any chance**?**	☐	☐
B. Are you nursing?	☐	☐
C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness or oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.	☐	☐

Policy Holder Name: _____

Employer: _____

I understand the importance of a truthful and complete Health History to assist my Oral Surgeon in providing the best care possible.
I have had the opportunity to discuss my Health History with my Oral Surgeon.

Date	Patient, Parent or Guardian Signature	Doctor's Initials
_____	_____	_____

OFFICE USE ONLY

Height: _____ **Weight:** _____ **Temperature:** _____ ◦**C** **Blood Pressure:** _____ **Pulse:** _____