Turlock
Oral & Maxillofacial Surgery

1810 N. Olive Ave., Suite #6, Turlock, CA 95382
Phone: (209) 667-5050

HEALTH HISTORY

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 ☐

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?	☐	☐
How frequent? _____ What causes it? _____		
6. Have you had or are you currently having neck pain?	☐	☐
How frequent? _____ What causes it? _____		
7. Have you had previous surgeries?	☐	☐
What? 1 _____ age _____		
2 _____ age _____		
3 _____ age _____		
4 _____ age _____		
8. Have you ever had a general anesthetic? (put to sleep for surgery)	☐	☐
9. Have you or anyone in your family had complications with general anesthesia?	☐	☐
10. Do you have diabetes?	☐	☐
11. Have you ever taken a prescription diet medication such as Fen-Phen, Redux or Bisphosphinates?	☐	☐
How recently? _____ For how long? _____		

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

	DOSE	Times when Taken
A		
B		
C		
D		
E		
F		

FOR WOMEN ONLY	YES	NO
13. Are you using an oral contraceptive?	☐	☐
14. Are you pregnant? Due date? _____	☐	☐
15. Are you trying to become pregnant at this time?	☐	☐
16. Are you aware that an antibiotic may interfere with the function of birth control pills?	☐	☐

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17. Have you had any of the following?

HEART DISEASE	YES	NO	If YES, When was this
Rheumatic Fever	☐	☐	_____
Heart Murmur	☐	☐	_____
High Blood Pressure	☐	☐	_____
Angina	☐	☐	_____
Heart Attack (Coronary)	☐	☐	_____
Abnormal Electrocardiogram (EKG)	☐	☐	_____
Heart Surgery	☐	☐	What? _____
Valve replacement?	☐	☐	_____
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 regularly?	☐	☐	_____
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	☐	☐	_____
Pneumonia	☐	☐	_____
Shortness of Breath	☐	☐	_____
EYE DISEASE	☐	☐	_____
Glaucoma	☐	☐	Any medications? _____
KIDNEY DISEASE	☐	☐	_____
GASTRIC (STOMACH) ULCER	☐	☐	When? _____
LIVER DISEASE	☐	☐	_____
Hepatitis (Yellow Jaundice)	☐	☐	_____
Cirrhosis	☐	☐	_____
TUMOR OR CANCER	☐	☐	_____
Radiation Therapy	☐	☐	_____
Chemotherapy	☐	☐	_____
Immune System Disease	☐	☐	_____
HERPES	☐	☐	Oral ☐ Genital ☐ _____
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)	☐	☐	_____

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

25. Weight _____Height _____

26. Are You Allergic To:	YES	NO
Penicillin	☐	☐
Demerol	☐	☐
Novacaine	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Barbiturates	☐	☐
Other Drugs	☐	☐
Latex	☐	☐

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_____

FOR 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 _____

_____

_____

_____

_____

_____