SALMON CREEK
Oral Surgery & Periodontics

HEALTH HISTORY

Patient's Name:_____ Date:_____

Answer all questions by circling Y (yes) or N (no). All responses are kept confidential.

Are you in good health?..... Y N
Has there been any change in your general health in the past year?..... Y N
Date of last physical exam:……. Y N
Have you **ever** had any serious illnesses, operations or hospitalizations:…….. Y N
If so, describe:_____
_____
Are you now under a physician's care for a particular problem?.....…….. Y N
Height:_____ Weight:_____

DO YOU HAVE OR HAVE YOU EVER HAD (circle what applies):

A. Rheumatic Fever or Rheumatic heart disease…… Y N
B. Congenital Heart Disease…….. Y N
C. Cardiovascular Disease (Heart attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)?..... Y N
D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?..... Y N
E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?..... Y N
F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion, Bruise Easily…… Y N
G. Liver Disease (Jaundice, Hepatitis?)…… Y N
H. Kidney Disease?..... Y N
I. Diabetes?..... Y N
J. Thyroid Disease (Goiter)?..... Y N
K. Arthritis?..... Y N
L. Stomach Ulcers or Colitis?..... Y N
M. Glaucoma?..... Y N
N. Implants (Heart Valve, Pacemaker, Hip, Knee, Tooth, Other)…… Y N
O. Radiation (x-ray) treatment for cancer?..... Y N
P. Clicking or popping of the jaw joint, pain near ear, difficulty opening mouth, Grinding or clenching teeth?..... Y N
Q. Sinus or Nasal problems?..... Y N
R. Any disease, drug or transplant operation that has depressed your Immune System?..... Y N

ARE YOU USING ANY OF THE FOLLOWING MEDICATONS (circle what applies):

A. Antibiotics…… Y N
B. Anti-coagulants (blood thinners, Coumadin)…… Y N
C. NSAIDs (Aspirin, Tylenol, Aleve, Motrin, Ibuprofen, Naproxen)…….. Y N
D. High Blood Pressure Medications?..... Y N
E. Steroids (Cortisone, Prednisone)……. Y N
F. Insulin or Oral Anti-Glycemic Medications…….Y N
G. Tranquilizers?..... Y N

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Continued

H. Digitalis, Inderal, Nitroglycerin or other heart medications?........................ Y N
I. Biphosphonate medications (Fosamax, Boniva, Actonel, Dridronel)……… Y N
J. Please list any and all medications taken, including prescription medications, over the Counter medications, herbal or holistic remedies, vitamins or minerals?_______________

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ARE YOU ALLERGIC TO OR HAVE HAD AN ADVERSE REATION TO:

A. Local Anesthesia (Novocaine, etc?)………………………………………. Y N
B. Penicillin or other antibiotics?... Y N
C. Sedatives, Barbiturates, Narcotics, Codeine?.. Y N
D. Aspirin, Ibuprofen or other NSAIDS?.. Y N
E. Latex or Rubber Products?... Y N
F. Soy or Soy Products?.. Y N
G. Sulfa or Sulfur?... Y N
H. Other allergies or reactions? Please list? ____

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Do you smoke or chew tobacco?.. Y N
How much per day?__________________

Is there any past history of Alcohol or Chemical Dependency or emotional disorder that may affect the care we provide?... Y N

Have you had any serious problems associated with any previous dental treatment? Y N

Have you or an immediate family member had any problem associated with Intravenous Anesthesia or General Anesthesia?... Y N

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ____

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Do you wish to talk to the doctor privately for anything?.. Y N

For women only:

A. Are you pregnant or **is there any chance** you might be pregnant?................ Y N
B. Are you nursing?.. Y N
C. **If you are using Oral Contraceptives**: It is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of 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.

____ __________________________

Signature of Person Completing Health History **Date**

Doctor's Initials:_________

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Medical Update: I have read my health history dated __________________ and confirm that it adequately states past and present conditions:

Date:____________________ Exceptions or Changes:______________________________________

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Patient's Signature:_____________________________________ Doctor's Initials:______________
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