FLORIDA ORAL SURGERY

Florida Oral Surgery
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HEALTH HISTORY INFORMATION

NAME_____DATE_____

PLEASE CHECK THE BOXES THAT APPLY TO YOUR PAST AND CURRENT HEALTH CONDITIONS:

MEDICAL HISTORY
- ☐ ARTHRITIS
- ☐ PAINFUL/SWOLLEN JOINTS
- ☐ EYE PROBLEMS (GLAUCOMA)
- ☐ STOMACH ULCERS
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ VOMITING OR ACID REFLUX
- ☐ KIDNEY/BLADDER TROUBLE
- ☐ HEAD OR NECK INJURY
- ☐ BACK/NECK PAIN
- ☐ SHORTNESS OF BREATH
- ☐ HEADACHE/MIGRAINES
- ☐ SWOLLEN ANKLES
- ☐ PNEUMONIA
- ☐ CHRONIC COUGH
- ☐ FRACTURE OR DISLOCATION
- ☐ NUMBNESS OR TINGLING ANY WHERE
- ☐ THYROID PROBLEMS
- ☐ WEIGHT CHANGE OVER 20 LBS IN PAST YEAR
- ☐ ASTHMA, DATE OF LAST ATTACK _____

DISEASES/DISORDERS
- ☐ EXPOSED TO TUBERCULOSIS
- ☐ AIDS/HIV
- ☐ SKIN DISEASE
- ☐ DIABETES
- ☐ ANEMIA
- ☐ HEPATITIS/JAUNDICE
- ☐ LIVER DISEASE
- ☐ DEFECTIVE IMMUNE SYSTEM
- ☐ EPILEPSY/SEIZURES
- ☐ NEUROLOGIC DISORDER
- ☐ BRONCHITIS/EMPHYSEMA
- ☐ HORMONE REPLACEMENT
- ☐ OSTEOPOROSIS/THINNING BONES
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ SLEEP APNEA/SNORING

CANCER
- ☐ CHEMOTHERAPY
- ☐ RADIATION THERAPY
- ☐ LEUKEMIA
- ☐ CANCER OR TUMOR

ALLERGIES
- ☐ FOOD
- ☐ LATEX
- ☐ METALS
- ☐ SEASONAL ALLERGIES
- ☐ LOCAL ANESTHETIC
- ☐ LIDOCAINE
- ☐ MEDICATIONS:
- ☐ _____

HEALTH CONCERNS
- ☐ SMOKING
- ☐ RECREATIONAL DRUGS OR SUBSTANCES
- ☐ RECOVERING SUBSTANCE ABUSER
- ☐ LUNG INFECTION
- ☐ VASCULAR SHUNT (FOR HEMODIALYSIS OR DRUG THERAPY)

HEART
- ☐ HEART DISEASE
- ☐ HEART INFECTION
- ☐ HEART MURMUR
- ☐ HEART TRANSPLANT
- ☐ HEART DEFECT
- ☐ HEART ATTACK
- ☐ ANGINA/CHEST PAIN
- ☐ PROSTHETIC HEART VALVE
- ☐ REPAIRED HEART DEFECT
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ PACEMAKER/DEFIBRILLATOR
- ☐ VASCULAR OR CARDIAC REPAIR

BLOOD
- ☐ BRUISE OR BLEED EASILY
- ☐ BLEEDING PROBLEMS
- ☐ STROKE

MENTAL
- ☐ DEPRESSED/BIPOLAR
- ☐ CHANGE IN MEMORY
- ☐ NERVOUS BREAKDOWN
- ☐ PANIC ATTACK
- ☐ PSYCHIATRIC CARE OR COUNSELING
- ☐ A.D.D./A.D.H.D.

SURGERIES
- ☐ IMPLANTS
- ☐ PROSTHETIC JOINTS
- ☐ ORGAN OR BONE MARROW TRANSPLANT
- ☐ OTHER_____

ORAL
- ☐ I HAVE HAD LOCAL ANESTHESIA
- ☐ I HAVE HAD GENERAL ANESTHESIA
- ☐ HURTS TO CHEW
- ☐ JAW MAKES CLICKING SOUND
- ☐ EAR ACHES

PREGNANCY
- ☐ NURSING

IS IT POSSIBLE YOU ARE PREGNANT?
- ☐ YES
- ☐ NO

IF YES, PLEASE INDICATE DUE DATE:
_____
FIRST DAY OF YOUR LAST PERIOD:
_____

MEDICATIONS
- ☐ BLOOD THINNERS
- ☐ MEDICINE FOR OSTEOPOROSIS
- ☐ FOSAMAX OR ACTONEL
- ☐ BIRTH CONTROL
- ☐ BLOOD PRESSURE MEDICINE
- ☐ CHOLESTEROL MEDICINE
- ☐ PLEASE LIST OTHER MEDICATIONS

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OPTIONAL: RELIGIOUS PREFERENCE

_____

PATIENT SIGNATURE

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