**RAMAPO ORAL AND MAXILLOFACIAL SURGERY, P.C.**

**HEALTH HISTORY**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Answer all questions by checking:** Yes (x) No (x)

 **ALL RESPONSES ARE KEPT CONFIDENTIAL**

* Are you in good health Yes ( ) No ( )
* Date of last physical exam\_\_\_\_\_\_\_\_\_\_\_
* Has there been any changes in your general health in the past year Yes ( ) No ( )

Are you under a doctor’s care Yes ( ) No ( )

Sinus or nasal problems Yes ( ) No ( )

Any disease or transplant operation Yes ( ) No ( )

Have you ever had any serious

Illness, operations, or hospitalizations Yes ( ) No ( )

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MD’s Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Medical Doctor: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Height\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_

**DO YOU HAVE OR HAVE YOU HAD:**

* Rheumatic Fever or heart disease Yes ( ) No ( )
* Congenital Heart Disease Yes ( ) No ( )
* Cardiovascular disease (heart attack,

heart trouble, murmur, coronary artery

disease, angina, high blood pressure,

 stroke, heart surgery, palpitations,

pacemaker, **Please circle**. Yes ( ) No ( )

* Lung disease (asthma, emphysema,

chronic cough, bronchitis, pneumonia,

tuberculosis, shortness of breath, chest

pain, severe cough. **Please circle.** Yes ( ) No ( )

* Seizures, convulsions, epilepsy,

fainting, or dizziness. **Please circle.** Yes ( ) No ( )

* Bleeding disorders, anemia,

blood transfusion, do you

bruise easily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ( ) No ( )

* Liver disease, (Jaundice, Hepatitis) Yes ( ) No ( )
* Kidney disease Yes ( ) No ( )
* Diabetes Yes ( ) No ( )
* Thyroid disease (goiter) Yes ( ) No ( )
* Arthritis Yes ( ) No ( )
* Stomach ulcers or colitis Yes ( ) No ( )
* Glaucoma
* Implants placed anywhere in your body

(heart valve, pacemaker, hip, knee) Yes ( ) No ( )

* Clicking or popping of jaw joints, pain near

the ear, difficulty opening mouth, grinding

or clenching of the teeth. Yes ( ) No ( )

* Radiation (x-ray) treatment for cancer:

If so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Sinus or nasal problems Yes ( ) No ( )
* Any disease, drug or transplant Yes ( ) No ( )

**ARE YOU USING ANY OF THE FOLLOWING:**

* Antibiotics Yes ( ) No ( )
* Bisphosphonate Drugs Yes ( ) No ( )
* Anticoagulants (blood thinner) Yes ( ) No ( )
* Aspirin, Aleve, Motrin, Ibuprofen,

Plavix, Coumadin, Warfarin, etc. Yes ( ) No ( )

* High Blood pressure medication Yes ( ) No ( )
* Steroid (Cortisone, etc) Yes ( ) No ( )

**Please list ANY AND ALL prescription and over the**

**counter medication taken including herbal or**

**holistic remedies, vitamins or minerals:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR WOMEN ONLY:

**Are you allergic to or have you had an adverse reaction**

**to any foods or medications. Please List:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you allergic to or have you had an adverse reaction to General Anesthesia/ IV Sedation.** Yes ( ) No ( )

If yes, please expain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any other disease, condition, or problem**

**not listed above? Please List:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any past history of Alcohol or Chemical

Dependency or emotional disorders Yes ( ) No ( )

Do you smoke or chew tobacco Yes ( ) No ( )

 D o you wish to speak to the doctor privately Yes ( ) No ( )

* Are you pregnant, or is there a chance you might be pregnant \_\_\_\_\_\_\_\_\_\_ Yes ( ) No ( )
* Are you nursing Yes ( ) No ( )
* Are you using oral contraceptives Yes ( ) No ( )

It is important that you understand that

antibiotics (and some medications) may

interfere with the effectiveness of oral

contraceptives. Therefore, you will need

to use alternative forms of birth control

for one complete cycle of birth control pills

after the course of antibiotics or other

medications are completed. Please consult

gynecologist for further guidance.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing, I am certifying that I have provided to the best of my

knowledge, a truthful medical history.