ICON
ORAL SURGERY

Health History

Patient Name:_____ Date of Birth: _____

Height:_____ Weight:_____ Sex(circle one): Male Female

Dental History

Please describe why you are in the office today: _____

Are you having any dental pain at this time? Yes / No

If Yes, please describe: _____

Have you had any adverse effects from dental treatment? Yes / No

If Yes, please describe: _____

Medical History

Please describe your current overall health (circle one): Excellent Good Fair Poor

Have there been any changes in your general health in the past year? Yes / No

If Yes, please describe: _____

Are you now under a doctor's care for a medical condition? Yes / No

Date of last physical exam: _____ Reason: _____

Name of physician: _____ Physician Phone: _____

Have you ever been hospitalized or had a serious illness? Yes / No

If Yes, please describe: _____

Have you ever had any surgery? Yes / No

If Yes, please describe: _____

Do you have, or have you ever had, any of the following conditions (circle Yes or No)**:**

Heart attach, stroke, or TIA	Yes / No	Congestive Heart Failure	Yes / No
Heart murmur or congenital heart disease, valve replacement, pacemaker placement, or any heart or cardiac surgery	Yes / No	Kidney disease or kidney failure or need dialysis	Yes / No
High blood pressure or hypertension	Yes / No	Osteoporosis or osteopenia	Yes / No
Irregular heart beat or atrial fibrillation	Yes / No	Diabetes	Yes / No
Autoimmune disease like lupus or rheumatoid arthritis	Yes / No	Bleeding disorder, had a blood transfusion, or bruise easily	Yes / No
HIV/AIDS	Yes / No	Shortness of breath or chest pain	Yes / No
Emphysema, chronic bronchitis or COPD	Yes / No	History of hip or knee replacement	Yes / No
Liver disease like cirrhosis, jaundice, or hepatitis	Yes / No	Stomach ulcers, GERD/acid reflux or colitis	Yes / No
Sinus or nasal problems	Yes / No	Thyroid disease	Yes / No
Sleep apnea or snore	Yes / No	Glaucoma	Yes / No
Asthma	Yes / No	Cancer: Diagnosis _____	Yes / No
Problems with general anesthesia, intravenous sedation, local anesthesia, other:_____	Yes / No	Treatment _____	

Do you have any other medical conditions that are important for your doctor to know about?_____

Family Medical History (circle Yes or No)

Family history of bleeding problems? Yes / No Family history of cancer? Yes / No Relationship: _____

Has an immediate family member had any problems with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No

If Yes, please describe: _____

Allergies (circle Yes or No)

Latex?	Yes / No	Food or food products?	Yes / No
Aspirin, ibuprofen, or naproxen (NSAIDs)	Yes / No	Penicillin?	Yes / No
Codeine, morphine, or other pain medication?	Yes / No	Other antibiotics? _____	Yes / No
Local Anesthetic?	Yes / No		Yes / No

Please list any other Allergies: _____

Social History (circle Yes or No)

Do you, or have you ever smoked tobacco or vaped nicotine? Yes / No

Have you ever sought professional care or been hospitalized for:		Do you use:	
Substance abuse	Yes / No	Alcohol	Yes / No
Emotional Disorders	Yes / No	How much per week? _____	
Alcoholism	Yes / No	Cannabis	Yes / No
		How often? _____	
		Recreational drugs	Yes / No

Female Patients (circle Yes or No)

Are you pregnant?	Yes / No	Any chance you might be pregnant?	Yes / No
Nursing?	Yes / No	On birth control?	Yes / No

Medications Have you been prescribed or taking any of the following? (circle Yes or No)

Blood thinners or anticoagulants	Yes / No	Medication for weight loss or diabetes	Yes / No
Bisphosphonates or other medications to strengthen your bones	Yes / No	Chemotherapy or cancer treatment including radiation	Yes / No

Please list any medications that you are currently taking including all prescription medications, drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:_____

_____

_____

_____

Do you wish to talk to the Doctor about anything in private? Yes / No

I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

_____ _____

Printed name of patient/parent/guardian **Patients DOB**

_____ _____

Signature **Date**