LSUHSC Oral and Maxillofacial Surgery - **Health History Form**

Patient's Name ______________________________ Date of Birth _____/_________/_________ Gender: _________________
SSN: ___________________________________ Phone Number: ___________________ Email: ___________________
Address: ____
Preferred Contact Method for Appointment Reminders: Text Message Phone Call Email
Emergency Contact Name: ___________________________ Emergency Contact Phone Number: ___________________________

Responsible Party (Primary Insurance Subscriber) Information: □ same as patient information

Name: ___________________________________ Relationship: _________________________
SSN: _____________________________________ Date of Birth: _________________________

Please bring your insurance card to your first appt, if you do not have an insurance card, please enter the information below.

Medical Insurance Information	Dental Insurance Information
Insurance Company: ___________________________	Insurance Company: ________________________
Member ID: _________________________________	Member ID: __________________________________
Group Number: ______________________________	Group Number: ___________________________

PATIENT MEDICAL HISTORY

Weight: ______________ Height: _______________
What problems are you having today? ____
Are you now under a doctor's care for a particular problem at this time? Yes No
If yes, why? ____ Date of last Doctor's Visit: ____/____/_____
Have you ever been hospitalized or had a serious illness? Yes No
If yes, why? ____

Do you have or have you ever had:

Heart disease or problems?	Yes	No	Lung disease or breathing problems?	Yes	No
Implants placed in your body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia? Do you bruise easily?	Yes	No
Kidney failure?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Arthritis?	Yes	No
Stomach ulcers?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within your jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, or fainting?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Diabetes?	Yes	No	Sleep apnea?	Yes	No
Any cancer, radiation, or chemotherapy?	Yes	No	Osteoporosis?	Yes	No

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: ____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes?	Yes	No	Relationship _______________	Cancer?	Yes	No	Relationship ______________
Heart disease?	Yes	No	Relationship _______________	Bleeding problems?	Yes	No	Relationship ______________
Tumors?	Yes	No	Relationship _______________	Lung disease?	Yes	No	Relationship ____________
Sleep Apnea?	Yes	No	Relationship _______________				

FEMALE PATIENTS

Are you pregnant? Yes No

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MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Prescription pain medication?	Yes	No
Blood thinners?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or diabetes medicine?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No
Antianxiety agents, antidepressants or other psychiatric medications?	Yes	No	Bisphosphonates, medications to strengthen your bones, or any IV medications or Cancer drugs? ________________________________	Yes	No

Please list all medications including those listed above:

Medication	**Dosage**	**Medication**	**Dosage**

ALLERGIES

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

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _______________ Relationship? __________________

Other drug or food allergies not listed above:

____

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes No If yes, for how long? ____________________________________

Have you ever sought care or been hospitalized for:

Substance abuse?	Yes	No
Emotional disorders?	Yes	No
Alcoholism?	Yes	No

Do you use:

Alcohol?	Yes	No	How often? ______________
Marijuana?	Yes	No	How often? ______________
Recreational drugs?	Yes	No	How often? ______________

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? ____________________________________

____

Do you wish to talk to the doctor privately about anything? Yes No

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

____ ______________________________

Signature of patient, parent, guardian   Date

____ ______________________________

Printed name of patient, parent, guardian/Relationship   Doctor's Signature