HEALTH HISTORY

Greater Louisville Oral & Maxillofacial Surgery Associates, P.S.C.

Patient's Name _____ Date of Birth _____

Pharmacy Name _____ **Pharmacy Address** _____ **Pharmacy Phone #** _____

Answer all questions by circling Yes (Y) or No (N)

1. Have you ever had any serious illnesses, operations or hospitalizations? Y N

   If so, describe _____

2. Height _____ Weight _____

3. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Heart Disease/Murmur Y N
   - B. Rheumatic Fever Y N
   - C. High Blood Pressure Y N
   - D. Stroke Y N
   - E. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Tuberculosis) Y N
   - F. Seizures, Epilepsy, Fainting or Dizziness Y N
   - G. Liver Disease (Hepatitis, Cirrhosis) 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, Artificial Joints) Y N
   - O. Radiation Treatment for Head & Neck Cancer Y N
   - P. Clicking or popping of jaw joint, pain near ear difficulty opening mouth, grind or clench teeth Y N
   - Q. Sinus or Nasal problems Y N
   - R. AIDS/HIV or any other disease or drug which has suppressed your immune system Y N
   - S. Depression Y N
   - T. Psychiatric or Emotional Disorder Y N
   - U. Cancer Y N
   - V. Sleep Apnea Y N

4. Do you smoke tobacco or marijuana or chew tobacco? Y N
   If yes, how many packs per day? _____

5. Is there any history of alcohol or chemical dependency? Y N
   If yes, what? _____

   Do you use any recreational drugs? Y N
   If yes, what? _____

   Do you consume 3 or more alcoholic drinks per day? Y N

6. Have you or an immediate family member had any serious problems with anesthesia? Y N

7. Do you have any other conditions, not listed above, that you think the doctor should know about? Y N

8. Do you have anything you wish to speak to the doctor privately about? Y N

All responses are kept confidential

9. Do you have any bleeding disorders or anemia? Y N

10. Are you taking or have you ever taken bisphosphonates for osteoporosis or cancer (Drug names: Fosamax, Actonel, Boniva, Aredia, Zometa, Reclast, Xgeva)? Y N

11. Are you on any blood thinners? Y N

12. Please list all medications which you take, including over-the-counter and herbal medications.

    _____

    _____

    _____

    _____

    _____

13. Are you allergic or have you had an adverse reaction to any of the following:
    - A. Antibiotics? Y N
    - B. Pain medications? Y N
    - C. Anesthesia agents? Y N
    - D. Latex? Y N
    - E. Please list all allergies below

    _____

    _____

    _____

14. **FOR WOMEN ONLY**
    - A. Are you pregnant, or **is there any chance you are Pregnant**? Y N
    - B. Are you nursing? Y N
    - C. **If you are using birth control pills**, please be aware that antibiotics may reduce the effectiveness of oral contraceptives. Therefore, you will need to use another form of birth control for one complete cycle of birth control pills, after you have completed an antibiotic prescription. Please consult your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

_____ _____ _____

Date Signature of Person Completing Health History Doctor's Initials