LOUISIANA ORAL & IMPLANT SURGERY

Health History

Name: ______________________________ Date: ________________________

Please answer all questions, as this will help us keep you safe throughout your treatment at Louisiana OIS.

Are you currently under the care of a physician? Yes No
If yes, Why? ____

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Have you ever been hospitalized or had a serious illness? Yes No
If yes, Why? ____

Heart Problems:

Heart attack	Yes	No
Chest pain / Angina	Yes	No
High blood pressure	Yes	No
Prosthetic heart valve	Yes	No
Congestive Heart Failure (CHF)	Yes	No
Heart bypass surgery (CABG)	Yes	No
Heart stents	Yes	No
Congenital heart defect	Yes	No
Pacemaker / defibrillator (ICD)	Yes	No
Infective endocarditis	Yes	No
Heart Palpitations	Yes	No
Irregular heart beat (arrhythmia)	Yes	No
Rheumatic fever / heart disease	Yes	No

Breathing / Lung Problems:

Asthma	Yes	No
COPD	Yes	No
Sleep apnea (OSA)	Yes	No
Shortness of breath	Yes	No
Bronchitis / Emphysema	Yes	No
Tuberculosis	Yes	No
Cough	Yes	No

Bleeding Problems:

Bleeding disorders	Yes	No
Blood thinners (e.g. coumadin)	Yes	No
Sickle Cell Disease	Yes	No
HIV/AIDS	Yes	No
Easy bruising	Yes	No

Head, Eyes, Nose & Throat Problems:

Headaches	Yes	No
TMJ clicking or pain	Yes	No
Glaucoma	Yes	No
Sinus or nasal problems	Yes	No

Liver/Digestive Problems:

Liver disease	Yes	No
GERD / Acid reflux	Yes	No
Liver cirrhosis	Yes	No
Hepatitis or Jaundice	Yes	No

Endocrine Problems:

Diabetes	Yes	No
Thyroid disorders	Yes	No

Nervous system problems:

Stroke/TIA (mini stroke)	Yes	No
Seizures / Epilepsy	Yes	No
Neuropathy / Nerve pain	Yes	No
Tingling or numbness	Yes	No
Cerebral palsy	Yes	No
Fainting spells	Yes	No

Mental Health:

Eating disorder	Yes	No
Emotional disorder	Yes	No
Dementia	Yes	No
Depression	Yes	No
Anxiety / Panic disorder	Yes	No

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Joint/Bone Problems:

Arthritis	Yes	No
Joint replacement (e.g. hip, knee)	yes	No
Osteoporosis	Yes	No

Kidney:

Kidney disease	Yes	No
Kidney failure	Yes	No
Dialysis	Yes	No

Other (Important):

History of radiation treatment	Yes	No
Cancer or Tumors	Yes	No
Chemotherapy	Yes	No

Women Only:

Pregnancy or chance of pregnancy	Yes	No
Breastfeeding	Yes	No

Anesthesia:

Family history of anesthesia complications or problems	Yes	No

Substance:

Tobacco use	Yes	No
Alcoholic Beverages	Yes	No
Recreational (street) drugs	Yes	No

Please list all previous surgeries you have had:

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____
____

Allergies:

Penicillin/Amoxicillin	Yes	No
Other antibiotics	Yes	No
Pain medications	Yes	No
Local anesthetics	Yes	No

Please list all drug allergies/reactions:

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____
____

Medications:

Blood thinners	Yes	No
Coumadin or Plavix	Yes	No
Bisphosphonates	Yes	No
Fosamax/Boniva/Reclast	Yes	No
Zometa/Actonel/Aredia	Yes	No
Pain Medications	Yes	No
Steroids	Yes	No

Please list all medications you are currently taking (with doses):

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Patient / Guardian Signature: ____________________________________ **Date:**______________