



Roland I. Young, D.D.S., Inc.

ORAL AND MAXILLOFACIAL SURGERY

# HEALTH HISTORY

ALL RESPONSES ARE KEPT CONFIDENTIAL

**PATIENT'S NAME**

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

- 1. Are you in good health? .....Y N
- 2. Has there been any change in your general health in the past year? .....Y N
- 3. Date of your last physical exam: \_\_\_\_\_
- 4. Are you now under a physician's care for a particular problem? .....Y N  
Name of Physician \_\_\_\_\_  
Physician Address \_\_\_\_\_

- 5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe.....Y N  
\_\_\_\_\_

- 6. Height \_\_\_\_\_ Weight \_\_\_\_\_

**7. DO YOU HAVE OR HAVE YOU EVER HAD:**

- A. Rheumatic Fever or Rheumatic Heart Disease? ....Y N
- B. Congenital Heart Disease? .....Y N
- C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? .....Y N
- D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .....Y N
- E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? .....Y N
- F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .....Y N
- G. Liver Disease (Jaundice, Hepatitis)? .....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. Osteoporosis? .....Y N
- O. Implants place anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .....Y N
- P. Radiation (X-ray) treatment for Cancer? .....Y N
- Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?..Y N
- R. Sinus or Nasal problems? .....Y N
- S. Any disease, drug or transplant operation that has depressed your immune system? .....Y N

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

- A. Antibiotics? .....Y N
- B. Anticoagulants (Blood Thinners)? .....Y N
- C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
- D. High Blood Pressure medications? .....Y N
- E. Steroids (Cortisone, etc.)? .....Y N
- F. Tranquilizers? .....Y N

**DATE OF BIRTH**

**DATE**

- G. Insulin or Oral Anti-Diabetic drugs? .....Y N
- H. Digitalis, Inderal, Nitroglycerin or other heart drug?.....Y N
- I. Are you taking or **have you ever taken** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa)? .....Y N
- J. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

- A. Local Anesthesia (Novocaine, etc.)? .....Y N
- B. Penicillin or other antibiotics? .....Y N
- C. Sedatives, Barbiturates? .....Y N
- D. Aspirin or Ibuprofen? .....Y N
- E. Codeine or other pain killers? .....Y N
- F. Latex or Rubber products? .....Y N
- G. Other allergies or reactions? Please List .....Y N  
\_\_\_\_\_

- 10. Do you smoke or chew Tobacco? .....Y N  
How much per day? \_\_\_\_\_

- 11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .....Y N

- 12. Have you had any serious problems associated with any previous dental treatment? .....Y N

- 13. Have you or an immediate family member had any problem associated with intravenous anesthesia? .....Y N

- 14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .....Y N

- 15. Do you wish to talk to the doctor privately about anything? .....Y N

**16. FOR WOMEN ONLY:**

- A. Are you Pregnant, or **is there any chance** you might be Pregnant?.....Y N

- B. Are you nursing?.....Y N

C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with 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 \_\_\_\_\_

**Medical Update:** I have read my Health History dated \_\_\_\_\_ and confirm that it adequately states past and present conditions

**Patient Information**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Phone # \_\_\_\_\_  
SSN \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_ Cell # \_\_\_\_\_  
Married \_\_\_\_\_ Single \_\_\_\_\_ Minor \_\_\_\_\_ Widowed \_\_\_\_\_ Other \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone# \_\_\_\_\_  
Spouse or Parent \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone# \_\_\_\_\_  
If patient is a student, name of school or college \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone# \_\_\_\_\_

**Responsible Party  
If other than patient**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_ Phone# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SSN \_\_\_\_\_ Employer \_\_\_\_\_ Phone# \_\_\_\_\_

**Insurance Information**

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SSN \_\_\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_ Phone# \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_ Phone# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Do You Have Additional Insurance? If yes, please complete the following.**

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SSN \_\_\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_ Phone# \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_ Phone# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Financial Agreement for Patients with Insurance Coverage**

An estimate of benefits will be obtained from your insurance company for services to be rendered by Dr. Young. This is being done as a courtesy, so the estimated insurance benefit can be deferred. **Estimated patient portion is due at surgery appointment.** This is an estimate only, and there is no guarantee of coverage. Services will be performed with the agreement that any portion remaining after the insurance company pays will be paid in full within 30 days.

I accept this agreement and agree to pay any balance remaining after the insurance company pays.  
I also authorize payment directly to Dr. Young of the group insurance benefits otherwise payable to me.  
I understand that I am responsible for all costs of Oral Surgery.

**PLEASE SIGN  
HERE** 

**X**

\_\_\_\_\_  
(Patient, Parent or Guardian)

**DATE** \_\_\_\_\_

