HOLLINGER DENTAL GROUP

Oral Surgery Health History Form

Health Card Number _____

Age / Height / Weight _____

Name _____ Email Address _____

Do you currently have or have you had any of the following medical issues?

Rheumatic fever	Y	N	Blood transfusion	Y	N	Arthritis / joint disease	Y	N
Damaged heart valves	Y	N	Prolonged bleeding	Y	N	Osteoporosis / osteopenia	Y	N
Heart surgery / procedures	Y	N	Bruise easily	Y	N	Osteonecrosis	Y	N
Stents	Y	N	Infectious mononucleosis	Y	N	Taken bisphosphonates	Y	N
Heart attack	Y	N	Bleeding disorder	Y	N	Immunomodulating drugs	Y	N
Heart murmur	Y	N	Blood disorder	Y	N	Immunosuppressives	Y	N
Chest pain / angina	Y	N	Hepatitis / liver disease	Y	N	Transplants	Y	N
Pacemaker / defibrillator	Y	N	Jaundice	Y	N	Delay in healing	Y	N
Irregular heartbeat	Y	N	Gallbladder problems	Y	N	Tumor / growth / cancer	Y	N
High blood pressure	Y	N	Thyroid problems	Y	N	Eating disorder	Y	N
Low blood pressure	Y	N	Kidney problems	Y	N	Diet or diet pills	Y	N
Bacterial endocarditis	Y	N	Diabetes	Y	N	Radiation or chemotherapy	Y	N
Asthma	Y	N	Dialysis	Y	N	Chronic fatigue / night sweats	Y	N
Snoring / sleep apnea	Y	N	Fainting spells	Y	N	Mental health issues / treatment	Y	N
Sinus problems	Y	N	Convulsions / epilepsy	Y	N	Drug / alcohol use (past / present)	Y	N
Bronchitis / cough / emphysema	Y	N	Brain injury	Y	N	Eye disease / problems	Y	N
Shortness of breath	Y	N	Stroke	Y	N	Contact lenses	Y	N
Difficulty breathing	Y	N	Ulcers	Y	N	Implanted devices or prosthetics	Y	N
Lung disease / lung trouble	Y	N	Sexually transmitted diseases	Y	N	Pain or clicking of jaws / joints	Y	N
Tuberculosis	Y	N	Contagious diseases	Y	N	Removable dental appliance	Y	N
Smoke (past/present)	Y	N	HIV / AIDS	Y	N	Malignant hyperthermia	Y	N
Chewing tobacco	Y	N	Swollen ankles / legs / arms	Y	N	Venezuelan Ancestry	Y	N

Have you or anyone in your family had an adverse anesthetic event?	Y	N

Please list all hospitalizations, surgeries and implanted medical equipment / devices _____ _____	FEMALE PATIENTS ONLY Medications & X-rays may harm developing babies and/or make birth control less effective		
Please list all medications you take and/or are prescribed (including injections and infusions given by your doctors) _____ _____	Are you pregnant or nursing?	Y	N
Please list any allergies _____ _____	Are you on birth control?	Y	N

_____ _____

signature: patient (or legal guardian) date