Northern Star
Oral and Maxillofacial Surgery PLLC

HEALTH HISTORY

Please fill out this form thoroughly, and to the best of your knowledge in order for us to provide you with the best care possible.
ALL INFORMATION IS KEPT CONFIDENTIAL.

Patient Name: _____ **DOB:** _____ **Height:** _____ **Weight:** _____

1. Please list **ALL** medications you are presently taking, including prescribed, over the counter, herbals/supplements & vitamins:
   _____
   _____
   _____
   _____
2. Drug and other allergies: _____
3. Do you have, or have you had any heart problems such as heart attack, heart murmur, or heart valve replacement?_____ If so, please explain:_____
4. Do you have, or have you had any lung problems such as asthma, COPD, or emphysema? _____
5. Have you had any adverse reactions to the following: Local Anesthesia (Novocain, etc), Penicillin, Aspirin, Ibuprofen, Codeine or other pain killers, Latex or rubber products? _____ If so, please explain: _____
6. Please list all surgeries and hospitalizations with corresponding dates: _____
   _____
   _____
7. Have you, or an immediate family member, had any problems associated with intravenous sedation/general anesthesia? _____
   If so, please explain: _____
8. Are you, or have you ever, taken Bisphosphinates for osteoporosis or multiple myeloma (or other cancers) such as Reclast, Fosamax, Aconel, Boniva, Aredia, or Zometa? _____
9. Are you currently taking prescribed blood thinners such as Coumadin or Warfarin? _____
10. Have you ever had head or neck radiation associated with medical treatments such as cancer? _____ If so, please explain: _____
    _____
11. Do you currently have, or have you ever had any of the following:

High Blood Pressure	Y N	Joint Problems	Y N	Recreational Drug Use	Y N	**Women Only:**	
Shortness of Breath	Y N	Arthritis	Y N	Seizures	Y N	Currently Pregnant	Y N
Chest Pain	Y N	Back Problems	Y N	Cancer	Y N	Nursing	Y N
Diabetes	Y N	TMJ Problems	Y N	Glaucoma	Y N		
Liver Disease	Y N	Sinus Problems	Y N	Bleeding Disorders	Y N		
Hepatitis A, B, C	Y N	Current Smoker	Y N	Osteoporosis	Y N		
HIV/AIDS	Y N	Past Smoker	Y N	Sleep Apnea	Y N		
Artificial Joints	Y N	Chewing Tobacco	Y N	Thyroid Disease	Y N		

12. If you circled "Yes" to any of the above, please explain: _____
    _____
    _____
13. Is there anything else that you would like to tell about your health or dental history? _____
    _____
    _____
14. Do you wish to speak with the doctor privately about any concerns? _____
    _____

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. I understand it is my responsibility to complete the form correctly and completely. Any questions I have about this form have been answered and I understand the answers.

Patient or Guardian Signature: _____ **Date:** _____

OFFICE USE ONLY:

BP: _____ **P:** _____ **BMI:** _____ **Doctor's Initials:** _____