ORAL SURGERY ASSOCIATES OF PARIS

Patient Health History (Confidential)

Referring DDS_____

Name: _____ Gender:_____ Age: _____ Ht: _____ Weight_____

Have you been under the care of a physician in the last 12 months?_____ If so, reason:_____
_____

Have you been hospitalized in the past 3 years? _____ If yes, reason _____
_____

Have you had any surgeries in the past 5 years?_____If yes, please list _____
_____

Tobacco Use?_____How much and how long _____ Alcohol Use _____ How often _____
Do you have a history of cancer? _____ Site _____ Chemotherapy or Radiation? _____

Please circle any of the following if you have or have had in the past

High Blood Pressure	Asthma	Diabetes Type I	Sinus Congestion	Hepatitis A/B/C
Heart Disease/Attack	COPD/Emphysema	Diabetes Type II	Anemia	Liver Disease
Congestive Heart Failure	Shortness of Breath	Thyroid Condition	Kidney Problems	Stomach ulcers/Colitis
Heart Murmur	Pneumonia	Epilepsy/Seizures	Blood Clot Disorder	Fainting Spells
Heart Valve Defect	Stroke/TIA	Rheumatoid Arthritis	HIV/AIDS	_____

Anything else we should know of? _____

Female Patients

Any possibility of pregnancy? _____ Are you nursing? _____ Are you taking oral contraceptives? _____

Medications

Have you ever taken bone strengthening drugs known as Bisphoshonates (ie. Fosamax/Boniva/Zometa) _____
Are you on any blood thinning drugs (ex: Warfarin/Plavix/Eliquis) _____Reason _____

List any drug allergies and reactions: _____ Latex Allergy? _____
_____ Egg/Soy?_____

Please list all active medications/dosages currently taken

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Anything else the Doctor should know?_____

Patient Signature _____ Date: _____ Staff Init:_____