HEALTH HISTORY

Dr. Anthony R. Navilio, D.M.D. **Oral Surgery & Implant Center**

PLEASE PRINT **Today's Date: _____/_____/_____**

Patient's Name:____ Sex:_______ Age:_______

Birth date: _____/_____/_____ Social Security Number: ______________________________

Phone #'s: (home) __________________________ (work) __________________________

Street:_________________________________ City:___________________ State:_____ Zip:____________

Physician's Name:____________________________ Referring Dentist:____________________________

Reason for visit here:____

Please answer all questions by circling yes (y) or no (n) **All responses are kept confidential**

1. **Are you in good health? …………………………………………..** yes no
2. **Have there been any changes in your general health in the past year?** yes no
3. **Date of last physical exam: _____/_____/_____**
4. **Are you now under a physician's care for any particular problem?** yes no
5. **Have you had any serious illnesses, operations, or hospitalizations?**

If so, please list: ____

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6. **Have you had any adverse effects from oral surgery? …………** yes no
7. **Do you have or have you had?:**
   - **A. Rheumatic Fever or Rheumatic Heart Disease? ……………** yes no
   - **B. Congenital heart disease? …………………………………….** yes no
   - **C. Cardiovascular disease? (Heart attack, coronary artery disease, heart surgery, pacemaker, stents, chest pain, high blood pressure..** yes no
   - **D. Heart murmur (leaky valve)? ………………………………** yes no
   - **E. Stroke? ……………………………………………………….** yes no
   - **F. Lung disease? (asthma, emphysema, tuberculosis, bronchitis, shortness of breath, severe coughing, sleep apnea, etc.)…….** yes no
   - **G. Seizures, convulsion, epilepsy, fainting, nervous breakdown?** yes no
   - **H. Bleeding disorder, anemia, blood transfusions, bruising, etc?** yes no
   - **I. Liver disease? (jaundice, hepatitis, liver cancer) ……………** yes no
   - **J. Kidney disease? (nephritis, stones, renal failure, etc.) …….** yes no
   - **K. Arthritis? …………………………………………………….** yes no
   - **L. G.I. problems? (ulcers, colitis, etc.) ………………………..** yes no
   - **M. Glaucoma or other eye problems? ………………………..** yes no
   - **N. Frequent or recurring mouth sores? ………………………** yes no
   - **O. Implants place anywhere in the body? (heart valves, joints, etc.)** yes no
   - **P. Radiation treatments for cancer? …………………………** yes no

Q. TMJ problems? (clicking, popping, pain, clenching, etc.) yes no

R. Sinus or nasal problems? ……………………………….. yes no
S. Any disease, drug, or transplant operation that has depressed your immune system? ……………………………………… yes no
T. Recurrent infections of any kind? …………………………. yes no
U. Diabetes Type I or Type II? ……………………………….. yes no
V. Thyroid problems? ……………………………………… yes no

8. **Please list any and all medications you are currently taking or have taken within 2 weeks. Please include over the counter medications such as aspirin, vitamins, herbal meds, etc.:_______________**

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A. Have you EVER taken any of the biphosphonate or other class of medications such as antiangiogenic drugs and/or M-Tor inhibitors, usually used for osteopenia, osteoporosis, or metastatic bone cancer, or to prevent transplant rejection, such as Fosamax, Boniva, Aredia, Zometa, Didronel, Actonel, Reclast, Prolia, Xgeva, Rapamycin, etc? yes no. If yes, please list the name of the medication and dates taken:

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B. Marijuana or any illegal drugs? …………………………… yes no

Your Pharmacy Name and Number____

9. Are you allergic or had bad reactions to:
A. Local anesthetics? (Novocaine, etc.) ………………………. yes no
B. Penicillins, Amoxicillin, Cephalosporins, or other antibiotics? yes no
C. Barbiturates, sedatives, etc.? ………………………………... yes no
D. Aspirin, Ibuprofen, or similar? ……………………………. yes no
E. Codeine or other pain medications? ………………………... yes no
F. Latex or rubber products? ………………………………….. yes no
G. Other allergies or reactions? ……………………………….. yes no
If yes, please list: ____

10. Do you smoke or chew tobacco? …………………………………… yes no
11. Do you use alcohol? ………………………………………………… yes no
12. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? …………………………………………………… yes no
13. Do you wish to speak with the doctor privately about anything? yes no

14. Height ______________ Weight _______________ (Necessary for prescriptions and anesthesia)

14 For Women Only :

A. If you are using oral contraceptives than please understand that antibiotics, general anesthetics, and 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 medications are finished. Please consult your physician or OB/GYN for further guidance.

B. If you are pregnant, possibly pregnant, or trying to become pregnant, or if you are breast feeding than surgery, anesthetics, or any other medications may harm your developing or newborn baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant or if you are breast-feeding.

*****ARE YOU PREGNANT, POSSIBLY PREGNANT, OR TRYING TO BECOME PREGNANT?: yes no***
***** WOULD YOU LIKE TO TAKE A PREGNANCY TEST? yes no***

***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 THE DOCTOR.**

***SIGNATURE OF PERSON COMPLETING THIS HEALTH HISTORY AND DATE.**

SIGNATURE______________________________________DATE____/____/____ Doctors Initials_________