# North Atlanta Oral and Maxillofacial Surgery HEALTH HISTORY

# Revised 2025

**PATIENT’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Family Physician** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Pharmacy** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Specialist** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Family Dentist**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you taken any medicine or drugs during the past two years? CIRCLE: yes / no

1. Are you now taking any medications, drugs, or pills? **This includes any bone building drugs (Bisphosphonates) such as**

**Actonel, Boniva, Fosamax, Zometa, etc. Additionally, please list any ADHD, Anxiety, and/or Depression medications being taken.** If so, please list medicine and dosage –**please include Herbal**

**Meds/Supplements**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you allergic or have you reacted adversely to any of the following medications? CIRCLE:

Aspirin Nitrous Oxide Local Anesthetic

Valium Scopolamine (Novocaine or Xylocaine)

Darvon Erythromycin Sleeping Pills (Nembutal/Seconal)

Codeine Tetracycline Ibuprofen

Demerol Penicillin Amoxicillin

Percodan Other Antibiotics Latex

**Are you aware of being allergic to any other medication or substance? CIRCLE: yes / no**

If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Height:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight:** \_\_\_\_\_\_\_\_\_\_\_ Regular Exercise/Sport: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol: \_\_\_\_\_\_\_\_\_\_\_\_\_ Tobacco: \_\_\_\_\_\_\_\_\_\_ Vaping: \_\_\_\_\_\_\_\_\_\_\_ Recreational Drugs: \_\_\_\_\_\_\_\_\_\_\_ Snoring/Sleep Apnea: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

1. **Circle** any of the following that you, the patient, have had or have at the present.

**NOTE: It is imperative that all conditions, diagnoses, diseases are disclosed!**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
| Heart Failure |  |  | Emphysema Hearing Disorder |  |  |  |  |
| Heart Disease or Attack |  |  | Cough Blood Transfusion |  |  |  |  |
| Angina Pectoris |  |  | Tuberculosis Intellectual Disabilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |
| High Blood Pressure |  |  | Asthma or Shortness of Breath Hemophilia |  |  |  |  |
| Heart Murmur |  |  | Hay Fever Epilepsy or Seizures |  |  |  |  |
| Rheumatic Fever |  |  | Sinus Trouble Fainting or Dizzy Spells |  |  |  |  |
| Congenital Heart Lesions |  |  | Allergies or Hives ADD/ADHD |  |  |  |  |
| Scarlet Fever |  |  | Diabetes Asperger’s Syndrome |  |  |  |  |
| Artificial Heart Valve |  |  | Thyroid Disease Sexually Transmitted Disease |  |  |  |  |
| Heart Pacemaker |  |  | X-ray or Cobalt Treatment Drug Addiction |  |  |  |  |
| Heart Surgery |  |  | Chemotherapy Alcohol Abuse |  |  |  |  |
| Artificial Joints (Knee, Hip) |  |  | Arthritis Venereal Disease (Syphilis, Gonorrhea) |  |  |  |  |
| Anemia |  |  | Rheumatism Herpes |  |  |  |  |
| Stroke |  |  | Cortisone Medication Nervousness |  |  |  |  |
| Kidney Trouble |  |  | Glaucoma Bruise Easily |  |  |  |  |
| Ulcers |  |  | Pain in Jaw Joints Psychiatric Treatment |  |  |  |  |
| Cosmetic Surgery |  |  | Cold Sores Autism (w/ specifics): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |
| Sickle Cell Disease |  |  | Fever Blisters Liver Disease |  |  |  |  |
| Hepatitis A (Infectious) |  |  | Hepatitis B (Serum) Yellow Jaundice |  |  |  |  |
| **Other Conditions/Additional Info:**  **1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Heart: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  | **2.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **3.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Lungs:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mallampati:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |

# IT IS IMPERATIVE THAT THE SECTIONS BELOW ARE COMPLETED

**DETAILED AND ACCURATE PATIENT AND FAMILY MEDICAL HEALTH HISTORY IS CRITICAL**

Are you immune suppressed? \_\_\_\_\_ yes \_\_\_\_\_ no

Have you ever-required long-term antibiotic therapy? \_\_\_\_\_ yes \_\_\_\_\_ no

Do you have frequent oral sores? \_\_\_\_\_ yes \_\_\_\_\_ no

Do you require steroid medications in conjunction with medical treatment? \_\_\_\_\_ yes \_\_\_\_\_ no

1. **Have you, the patient, ever been admitted to the hospital for any reason?** (i.e. broken bones, childbirth, etc.) List reason and date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Have you, the patient, ever had surgery of any kind?** ( i.e. appendectomy, previous oral surgery) Have you had any problems with a previous general anesthesia? (i.e. post operative nausea/vomiting, reaction to medication) List procedure and date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In your **family medical history** (mother’s or father’s side of the family - up to the patient’s grandparents) is there a history of major illness/disease? (i.e. heart attack or heart disease, high blood pressure, stroke, cancer, diabetes, etc.) List family member and illness/disease:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. FOR WOMEN ONLY:

Are you pregnant? \_\_\_\_\_ yes \_\_\_\_\_ no Due date? \_\_\_\_\_\_\_\_\_\_\_\_

Are you nursing? \_\_\_\_\_ yes \_\_\_\_\_ no

Are you taking any form of birth control? \_\_\_\_\_ yes \_\_\_\_\_ no

**THE ABOVE INFORMATION IS TRUE.**

**Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT:**

The undersigned hereby authorizes a provider of North Atlanta Oral and Maxillofacial Surgery to order/take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the provider to make a thorough diagnosis of the patient’s oral and maxillofacial needs.

I understand that payment for my services provided in this office for my dependent or myself is mine is due at the time the services are rendered unless financial arrangements have been made. I further understand that any outstanding balances not paid within 90 days of the first statement are subject to additional fees due to any additional efforts that have to be taken by an outside collection agency.

I hereby authorize payment from my insurance company, directly to ***North Atlanta Oral and Maxillofacial Surgery***.

I also authorize release of any information related to this claim.

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***(***Signature of Patient, Parent, Guardian, or Responsible Party)

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please print name of Patient, Parent, Guardian or Responsible Party)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date Relationship to Patient