GREAT PLAINS
ORAL & MAXILLOFACIAL SURGERY, PA

PATIENT HEALTH HISTORY

Today's Date: _____

Your answers on this form will allow us to better understand your medical history and conditions. Please answer all questions completely and accurately. If you have any questions regarding answering specific items on this questionnaire, please ask one of our staff for assistance. **Thank You!**

PATIENT

Name: _____ Date of Birth: _____

Dentist's Name: _____ Phone Number: (____)_____
Physician's Name: _____ Phone Number: (____)_____
How did you hear about Great Plains OMS: _____

Height:_____ Weight:_____

I. Main reason for today's visit:

_____

_____

II. Do you currently have or have you ever had any of the following:

__High Blood Pressure __Dialysis
__Asthma __Emphysema __Bronchitis
__Other Pulmonary Disorders:_____
__Diabetes __Low Blood Sugar
__Stomach Ulcers
__Crohn's Disease __Ulcerative Colitis
__Other Stomach Disorders: _____
__Arthritis __Gout __TMJ Pain
__Seizures __Epilepsy
__Sleep Apnea __Sinus Problems
__Skin Diseases/Disorders
__Glaucoma __Other Eye Disorders:_____
__Thyroid Disorders/Adrenal Diseases
__Kidney/Bladder Diseases or Transplants
__Anemia __Sickle Cell Anemia
__Blood Clotting Diseases/Disorders
__Malignant Hyperthermia
__Hepatitis __HIV/AIDS __Liver Disease

III. Do you currently have or have you ever had any of the following conditions or used any of the following medications:

__Psychiatric Care
__Radiation __Chemotherapy
__Lengthy Hospitalizations
__Artificial Joints
__History of Blood Clots
__Cardiac Conditions
  __Heart Murmurs __Rheumatic Fever
  __Prosthetic Heart Valves
  __Pacemaker __Irregular Heartbeat
  __Cardiac Stents __Coronary Bypass
  __Stroke __Heart Attack
  __Endocarditis
  __Other Heart Conditions: _____
__Contact Lenses
__Blood Transfusions
__Lengthy Steroid Treatment
__Cancer
__Use of Blood Thinning Medications
  __Aspirin
  __Aggrenox (Dipyridamole)
  __Coumadin (Warfarin)
  __Lovenox (Enoxaparin)
  __Plavix (Clopidogrel)
  __Effient (Prasugrel)
  __Pentoxifylline (Trental, Pentoxil)
  __Pradaxa (Dabigatran)
  __Xarelto (Rivaroxahan)
  __Eliquis (Apixaban)

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IV. Do you have any medical issues not listed: Yes No

If yes, explain: _____

V. Women only:

Yes or No — Are you currently pregnant or nursing?

Yes or No — Are you taking birth control pills?

Please select below the osteoporosis medications that you currently take or have taken in the past.

Bisphosphonate Usage:

__Reclast (IV Zoledronic Acid)
__Prolia/Xgeva (Denosumab)
__Fosamax (Alendronate)
__Didronel (Etidronate)
__Zometa (IV Zoledronate)
__Boniva (Ibandronate)
__Skelid (Tiludronate)
__Aredia (IV Pamidronate)
__Actonel (Risedronate)
__Benofos (Clodronate)

Please list the length of time you have used the above medication(s):

_____

_____

VI. Allergies or reactions to medications:

1._____

2._____

3._____

4._____

5._____

Latex Local Anesthesia Food Allergies

VII. Prescriptive and non-prescriptive medications:

	Medication (Please list all medications, use additional sheets if needed)	Dose (mg/pill)	How Many Times per Day
1.			
2.			
3.			
4.			
5.			
6.			
7.			

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VIII. Surgical history (Please list ALL surgeries with dates):

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

IX. Social history (Have you ever):

Alcohol: Yes No _____# drinks per week and for how many years_____

Tobacco: Yes No _____# packs per day and for how many years_____

Recreational Drugs: Yes No History of substance abuse: Yes No

X. Family history (Please indicate the status of any of your immediate family members):

Yes or No		Yes or No	
	Heart Disease/Heart Attacks		Genetic Disorders
	Congenital Heart Problem		Cancer
	Hypertension		Malignant Hyperthermia
	Stroke		Diabetes
	Bleeding/Clotting Disorder		
	Anesthesia Complications:_____		

Other:_____

To the best of my knowledge, I have answered every question completely and accurately. I authorize Great Plains OMS, PA to furnish information to insurance companies as needed. I authorize payment from insurance company or companies to go directly to this office. I understand that I am financially responsible for charges for my treatment. I consent to the performing of advised and necessary procedures for diagnosis and treatment.

Patient (parent/legal guardian) Signature:_____Date:_____

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