Dr. Raju OMS Health History Form

Patient Name _____ DOB _____ Age _____ Ht _____ Wt _____

Primary Dentist _____ Primary Physician _____

Other Doctors _____

Reason for your visit today: _____

Are you currently in pain?	Y	N	Have you had recent fever, chills, night sweats, infection?	Y	N	Have a condition requiring antibiotic premedication?	Y	N

History of Illnesses/Conditions (Please Circle)

dental problems	Y	N	heart failure	Y	N	anemia	Y	N
clench/grind teeth	Y	N	shortness of breath	Y	N	hemophilia, sickle cell disease	Y	N
click/pop/pain of jaw joint (TMJ)	Y	N	heart murmur/heart defects	Y	N	organ transplant	Y	N
vision problems	Y	N	congenital heart disease	Y	N	HIV/AIDS	Y	N
currently wear contact lenses	Y	N	rheumatic fever	Y	N	blood transfusion	Y	N
glaucoma (open or closed angle)	Y	N	heart valve replacement	Y	N	diabetes	Y	N
ear problems	Y	N	abnormal heart rhythm	Y	N	hypothyroidism	Y	N
nasal obstruction	Y	N	pacemaker	Y	N	hyperthyroidism	Y	N
sinus problems	Y	N	lung problems	Y	N	steroid use	Y	N
seizures/epilepsy/convulsions	Y	N	COPD/emphysema/bronchitis	Y	N	osteoporosis/osteopenia	Y	N
stroke	Y	N	asthma	Y	N	osteoarthritis	Y	N
migraines, frequent headaches	Y	N	persistent cough	Y	N	prosthetic joint(s)	Y	N
chronic pain	Y	N	stomach ulcers	Y	N	Rheumatoid arthritis	Y	N
psychiatric care	Y	N	heart burn/GERD	Y	N	lupus	Y	N
depression, anxiety	Y	N	liver disease/cirrhosis/jaundice	Y	N	cancer, tumor	Y	N
heart trouble	Y	N	hepatitis	Y	N	radiation treatment	Y	N
heart surgery	Y	N	frequent nausea/vomiting	Y	N	chemotherapy	Y	N
angina/chest pain	Y	N	kidney problems	Y	N	bisphosphonate treatment	Y	N
heart attack	Y	N	dialysis	Y	N			
high blood pressure	Y	N	prolonged bleeding	Y	N	currently pregnant	Y	N
low blood pressure	Y	N	frequent bruising	Y	N	currently nursing	Y	N
dizziness/fainting on standing	Y	N	blood thinners	Y	N	currently on birth control	Y	N

Surgical History (List)	Y	N	**Medications/Drugs/Supplements (List)**	**Allergies**		
				Penicillin	Y	N
				Latex	Y	N
				Other (List)	Y	N
Any anesthetic complications?	Y	N				

Social History

Do you smoke or use tobacco?	Y	N	Do you drink alcohol?	Y	N	Do you use recreational drugs?	Y	N

Has a member of your family had a complication with surgery or anesthesia? _____

If there are any other medical diseases, conditions, problems or hospitalizations NOT listed on the form, please explain: _____

Patient or Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____