

Raj Guraya DDS, MD
Blue Ridge Oral and Facial Surgery
Health History Form

Patient's Name _____ Date of Birth ____/____/____

Gender: _____ Height: _____ Weight: _____

Name of Pharmacy you may prefer to use: _____

Do you read, speak and understand English: Yes or no (If No) Do you need a translator? Yes or No

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No

If yes, please describe: _____

Are you now under a doctor's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam ____/____/____

Have you ever been hospitalized or had a serious illness? Yes No

If yes, why? _____

Have you ever had surgery? Yes No

If yes, when and what for? Date of surgery: _____ Reason for surgery: _____

Date of surgery: _____ Reason for surgery: _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
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Implants or replacements placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
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Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
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Thyroid disease?	Yes	No	Arthritis?	Yes	No
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Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No
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Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
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Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
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Glaucoma?	Yes	No	Sleep apnea?	Yes	No
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Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No
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Any cancer, radiation, or chemotherapy? Yes No
 Describe: _____ Date of your last treatment? _____

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No
 If yes, please explain: _____

Health History Form

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes? Yes No Relationship _____	Cancer? Yes No Relationship _____
Heart disease? Yes No Relationship _____	Bleeding problems? Yes No Relationship _____
Tumors? Yes No Relationship _____	Lung disease? Yes No Relationship _____
Sleep Apnea? Yes No Relationship _____	

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Prescription pain medication?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No
Antianxiety agents, antidepressants or other psychiatric medications?	Yes	No	Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use.	Yes	No

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage	Medication	Dosage

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex? Yes No	Codeine or other pain killers? Yes No
Food products? Yes No	Aspirin, Motrin, Aleve, or ibuprofen? Yes No
Sedatives, barbiturates? Yes No	Penicillin or other antibiotics? Yes No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug or food allergies not listed above: _____

Health History Form

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:

Substance abuse? Yes No
Emotional disorders? Yes No
Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often? _____
Marijuana? Yes No How often? _____
Recreational drugs? Yes No How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? _____

Do you wish to talk to the doctor privately about anything? Yes No

**I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct**

Signature of patient, parent, guardian

Date

Printed name of patient, parent, guardian/Relationship

Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature
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_____	_____	_____
_____	_____	_____