iCare Oral Surgery
Dental Implant Center

William L. Thompson DDS, MD
Fellow of the American Board of Oral and Maxillofacial Surgery

HEALTH HISTORY

Patient Name: _____ Birthday _____/_____/_____

Gender: MALE / FEMALE Height: _____ Weight: _____

Describe your current health: EXCELLENT GOOD FAIR POOR

Describe the symptoms you are having today: _____

Are you under a physician's care at this time? YES NO Date of last physical _____/_____/_____

If yes, why? _____

Have you ever been hospitalized for a serious illness? YES NO

If yes, why? _____

HEART

High Blood Pressure	YES	NO
Heart Attack	YES	NO
Angina/Chest Pain	YES	NO
Heart Surgery/Stents	YES	NO
Pacemaker/Defibrillator	YES	NO
Congestive Heart Failure	YES	NO
Fluid in the lungs	YES	NO
Palpitation/Irregular heartbeat	YES	NO
Heart Murmur		

BLOOD

Anemia	YES	NO
Sickle cell disease	YES	NO
Blood clots in legs or lungs	YES	NO
HIV	YES	NO
History of Cancer	YES	NO
Do you take Blood Thinners?	YES	NO
Do you take Aspirin daily?	YES	NO
Recent infections	YES	NO
Blood Transfusions	YES	NO

NURO/PSYCHIATRY

Stroke	YES	NO
Seizure	YES	NO
Fainting	YES	NO
Dizziness	YES	NO
Headache	YES	NO
Depression	YES	NO
Anxiety	YES	NO
Psychiatric Care	YES	NO

LUNGS

Asthma	YES	NO
Bronchitis	YES	NO
Emphysema/COPD	YES	NO
Recent lung infection	YES	NO
Shortness of breath (With Activity)	YES	NO
Unable to lay flat on your back	YES	NO
Sleep apnea/CPAP use at home	YES	NO
Cough w/mucous production	YES	NO

STOMACH

Acid reflux/Heartburn	YES	NO

KIDNEY/LIVER

Urinary/kidney disease	YES	NO
Hemodialysis	YES	NO

ENDOCRINE

Diabetes	YES	NO
Do you take insulin?	YES	NO
Thyroid Disease	YES	NO
Steroids in the last year?	YES	NO

MUSCULOSKELETAL

Arthritis	YES	NO
Rheumatoid	YES	NO
Neck, Back, Leg, Arm problems	YES	NO

ANESTHESIA

Adverse reactions to anesthesia	YES	NO

iCare Oral Surgery
Dental Implant Center

William L. Thompson DDS, MD
Fellow of the American Board of Oral and Maxillofacial Surgery

MEDICATIONS – Please list all the medications you take regularly, including OTC medications

_____

_____

_____

_____

ALLGERIES

Latex	YES	NO	**Please list any other allergies you have:**
Penicillin	YES	NO	_____
Codeine	YES	NO	_____
NSAID's	YES	NO	_____

PRIOR SURGERIES – Please list the type and date of any surgeries you have had within the last 5 years.

_____

_____

_____

_____

SOCIAL HISTORY

Tobacco	YES	NO	How much?_____	How often?_____
Alcohol	YES	NO	How much?_____	How often?_____
Recreational Drugs	YES	NO	How much?_____	How often?_____
Marijuana	YES	NO	How much?_____	How often?_____

SLEEP APNEA QUESTIONNAIRE

Do you snore loudly?	YES	NO
Do you often feel tired, fatigued, or sleepy during the day?	YES	NO
Has anyone observed your stop breathing during your sleep?	YES	NO
Do you have or are you being treated for high blood pressure?	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.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Print Name Relationship