UNIVERSITY ORAL SURGERY CENTER
RAMIN SHABTIAE, DDS
HEALTH HISTORY

Patient Name:_____ Age:_____ Height:_____ Weight:_____
Please answer the following questions. Leave blank if you do not understand any question and ask the doctor.

Are you having pain or discomfort at this time?	Yes	No
Has there been a major change in your health in the last year?	Yes	No
Have you been a patient in the hospital during the past two years? If so, why?	Yes	No
_____		
Are you under the care of a physician?	Yes	No
Are you taking any medications, including Aspirin, blood thinners, steroids or over the counter drugs? **List here**	Yes	No
_____		
Have you ever taken any of the following medications: Fosamax, Boniva, Xgeva, Prolia, Zometa, Actonel, Reclast for treatment of cancer, osteoporosis or other bone diseases?	Yes	No
Do you take Viagra, Levitra or Cialis? When was the last time?_____	Yes	No
Have you been on diet medications (such as Phen fen)? Others:_____	Yes	No
Have you ever used, or are you using any recreational drugs including cannabis? Please list:_____	Yes	No
Are you **allergic** to Penicillin, Codeine, Sulfa, latex, Aspirin, Ibuprofen or any other drugs or medications?	Yes	No
If so, Please **list here**: _____		
Have you had a problem or bad experience with prior dental treatment? If so, explain	Yes	No
_____		
Have you been diagnosed with vitamin D deficiency?	Yes	No
Have you ever had excessive bleeding or do you have bleeding/bruising tendency?	Yes	No
Have you or close family member had any adverse reaction or complication with general anesthesia?	Yes	No
Have you ever been "pre-medicated" with antibiotics prior to any dental work?	Yes	No
Have you ever had radiation treatment for head and neck cancer or tumor?	Yes	No
Have you ever been diagnosed with any type of cancer or tumor? If so, explain_____	Yes	No
Do you smoke or use tobacco or vape? If so how much?_____	Yes	No
Have you ever had a blood transfusion?	Yes	No
Are you or have you been under psychiatric care?	Yes	No

Do you have:

High blood pressure	Yes	No	Asthma	Yes	No	Liver disease	Yes	No
Heart disease	Yes	No	Chronic cough	Yes	No	Jaundice	Yes	No
Stents/Angioplasty	Yes	No	Bronchitis	Yes	No	Venereal disease	Yes	No
Heart attack	Yes	No	Emphysema	Yes	No	Cold sores	Yes	No
Artificial heart valve	Yes	No	Tuberculosis	Yes	No	AIDS or HIV	Yes	No
Any heart surgery	Yes	No	COPD	Yes	No	Scarlet fever	Yes	No
Pace maker	Yes	No	Allergies/hay fever	Yes	No	Kidney disease	Yes	No
Internal defibrillator	Yes	No	Sinus disease	Yes	No	Bladder disease	Yes	No
Heart murmur	Yes	No	Thyroid disease	Yes	No	Chemotherapy	Yes	No
Irregular heart rate	Yes	No	Adrenal disease	Yes	No	Anemia	Yes	No
Congenital heart disease	Yes	No	Arthritis	Yes	No	Sickle cell	Yes	No
Rheumatic fever	Yes	No	Rheumatism	Yes	No	Fibromyalgia	Yes	No
Stroke	Yes	No	Diabetes	Yes	No	Migraines	Yes	No
Epilepsy/seizures	Yes	No	Blood disorder	Yes	No	Glaucoma	Yes	No
Osteoporosis	Yes	No	Skin disorder	Yes	No	Stomach disease/ulcers	Yes	No

Have you been experiencing any of the following symptoms:

Fainting/Dizziness	Yes	No	Nausea/vomiting	Yes	No	TMJ pain or noises	Yes	No
Palpitations	Yes	No	Diarrhea	Yes	No	Ringing in ears/vertigo	Yes	No
Shortness of breath	Yes	No	Difficulty swallowing	Yes	No	Dry mouth	Yes	No
Swollen ankles	Yes	No	Head aches	Yes	No	Joint pain/stiffness	Yes	No
Chest pain	Yes	No	Excessive thirst	Yes	No	Recent weight change	Yes	No

For Women:

Are you pregnant	Yes	No	Breast feeding	Yes	No	Taking contraceptives	Yes	No

Do you have any other medical problems not listed above? If so, please explain Yes No
_____

To the best of my knowledge, I have answered every question accurately and completely. I will inform this office about any changes to my health or medications. I authorize communication with my other doctors regarding my health history.

Patient's Signature:_____ Date_____ Dr._____