JON R. EWIG, D.D.S.
ORAL & MAXILLOFACIAL SURGERY

Please Print

HEALTH HISTORY

Date____________________________

Name____ Nickname______________________________
(FIRST) (MI) (LAST)

Address____

City____________________________________ State______________ Zip Code________________

Home Phone (_________)________________________ Work Phone (_________) __________________

Cell Phone (_________)________________________ Email__________________________________

Date of Birth_________________ Age __________ Sex M F Height_____________ Weight __________

Social Security Number ______________________ ☐ Single ☐ Married ☐ Widow ☐ Divorced

Occupation______________________________ Employer____________________________________

Name of Spouse/Parent(s) ____

Have you or any family members been a patient of Dr. Ewig's? Yes No ______________________________
Please list family members.

Dentist ______________________ Orthodontist ______________________ Referred By____________________

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Yes No Are you in good health? . . . .
Yes No Has there been any change in your health since last year? . . . .
My last physical exam was on ______________________________
Yes No Are you now under the care of a physician? . . . .
If so for what condition? ____
The name and address of my physician is: ____
____
____

Do you have or have you had any of the following diseases or problems? . . . .
Yes No Damaged heart valves, artificial valves or murmur . . . .
Yes No Rheumatic Heart Disease . . . .
Yes No Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition .
Yes No Chest pain on exertion? . . . .
Yes No Shortness of breath after mild exercise? . . . .
Yes No Do your ankles swell? . . . .
Yes No Seasonal allergies . . . .
Yes No Sinus trouble . . . .
Yes No Asthma or hay fever . . . .
Yes No Fainting spells or seizures . . . .
Yes No Diabetes . . . .
Yes No Hepatitis, jaundice or liver disease . . . .
Yes No Frequent or recurring mouth sores . . . .
Yes No Thyroid problems . . . .
Yes No Respiratory problems, emphysema, bronchitis, etc. . . . .
Yes No Arthritis or painful, swollen joints . . . .
Yes No Problems with/or medicines taken for bone density . . . .
Yes No Stomach ulcer or hyperacidity . . . .
Yes No Kidney trouble . . . .
Yes No Tuberculosis . . . .
Yes No Persistent cough or cough that produces blood . . . .
Yes No Persistent swollen neck glands . . . .
Yes No Low blood pressure . . . .
Yes No Epilepsy or neurological disorder . . . .
Yes No Problems with mental health . . . .
Yes No Cancer . . . .
Yes No Problems of the immune system (e.g. HIV) . . . .

Yes No Have you had abnormal bleeding?

Yes No Have you ever required a blood transfusion?

Yes No Do you have any blood disorder such as anemia?

Yes No Have you ever had treatment for a tumor or growth?

Are you allergic or have you had a reaction to:

Yes No Local anesthetics

Yes No Penicillin or antibiotics

Yes No Sulfa drugs

Yes No Barbiturates or sleeping pills

Yes No Aspirin

Yes No Iodine

Yes No Codeine or other narcotics

Yes No Other - (latex, etc.) ______

Yes No Have you had any serious trouble associated with previous dental treatment?

If so explain ______

Yes No Have you used or have you ever been addicted to drugs (e.g. Marijuana, Cocaine, LSD, Narcotics, etc.)?______

Yes No Do you have any other condition or disease you think I should know about?

If so explain ______

Yes No Do you have any vision problems, wear contacts or have glaucoma?

Yes No Are you wearing removable dental appliances?

Women

Yes No Are you pregnant?

Yes No Do you have problems associated with your menstrual period?

Yes No Are you nursing?

Yes No Are you taking birth control pills?

If you are using oral contraceptives, antibiotics and other medications may interfere with the effectiveness of these pills. DO YOU understand that you will need to use some other form of Birth Control for one complete cycle of pills after the course of antibiotics or other medications are completed? Yes No

Do you wish to have a pregnancy test? Yes No

Date of last menstrual period: ______.

MEDICATIONS: Please List - Include herbal supplements, vitamins and any medicine for bone density past/current.

Please list past surgeries or serious illnesses with dates.

Yes No **Is there anything you would like to speak to Dr. Ewig about privately?**

Do you drink alcohol? How Much: How Often:	Yes	No
Do you or have you ever used tobacco? (If YES, please circle type below) SMOKE: Cigarettes Cigars Pipe How Much: How Many Years: SMOKELESS: Chew Snuff How Much: How Many Years:	Yes	No

I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Guardian Doctor's Signature Date

Medical History Update:

Date	Comments	Signature