PORTLAND
ORAL & FACIAL SURGERY

Portland Oral & Facial Surgery Health History

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

Preferred Name: _____ Pronouns: _____

Sex Assigned at Birth: ☐ Male ☐ Female Date of Birth: _____/_____/_____

Primary Care Provider: _____ Phone #: _____

Preferred Pharmacy: _____ Phone #: _____

Personal Health History

Allergies to medications (Name of drug and the reaction you had)	

List your prescribed medications and over-the-counter drugs	

Check all medical problems or conditions that other doctors have diagnosed you with:			
☐ No medical problems or conditions			
☐ Anxiety	☐ High cholesterol	☐ Anesthesia complications	☐ Cleft lip and palate
☐ Depression	☐ Osteoporosis	☐ HIV	☐ Dementia
☐ ADHD	☐ Hypertension	☐ Hepatitis	☐ Sleep apnea
☐ Diabetes	☐ Joint replacement	☐ HX of bisphosphonate therapy	☐ TMJ
☐ Anemia	☐ Stroke	☐ Deep vein thrombosis (DVT)	☐ Parkinson's disease
☐ Asthma	☐ A-Fib	☐ Kidney disease	☐ Restless leg syndrome (RLS)
☐ Arthritis	☐ Hypothyroidism	☐ Brain Tumor	☐ Liver disease
☐ Heart Attack	☐ COPD	☐ Autism spectrum disorder	☐ Seizures
☐ Cancer Type: _____	☐ GERD (Acid reflux)	☐ Developmental delay	☐ Other:

**All questions contained in this questionnaire are strictly confidential.*

Please see reverse side

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Surgeries (Type and year)	

Health History

Illness or Condition:	Family Member:							
Diabetes	☐ Mother	☐ Father	☐ Sisters	☐ Brothers	☐ Grandmother (Maternal)	☐ Grandfather (Maternal)	☐ Grandmother (Paternal)	☐ Grandfather (Paternal)
Thyroid Disease	☐ Mother	☐ Father	☐ Sisters	☐ Brothers	☐ Grandmother (Maternal)	☐ Grandfather (Maternal)	☐ Grandmother (Paternal)	☐ Grandfather (Paternal)
Heart Disease	☐ Mother	☐ Father	☐ Sisters	☐ Brothers	☐ Grandmother (Maternal)	☐ Grandfather (Maternal)	☐ Grandmother (Paternal)	☐ Grandfather (Paternal)
Anesthesia Complications	☐ Mother	☐ Father	☐ Sisters	☐ Brothers	☐ Grandmother (Maternal)	☐ Grandfather (Maternal)	☐ Grandmother (Paternal)	☐ Grandfather (Paternal)
High Cholesterol	☐ Mother	☐ Father	☐ Sisters	☐ Brothers	☐ Grandmother (Maternal)	☐ Grandfather (Maternal)	☐ Grandmother (Paternal)	☐ Grandfather (Paternal)
Hypertension High Blood Pressure	☐ Mother	☐ Father	☐ Sisters	☐ Brothers	☐ Grandmother (Maternal)	☐ Grandfather (Maternal)	☐ Grandmother (Paternal)	☐ Grandfather (Paternal)
Liver Disease	☐ Mother	☐ Father	☐ Sisters	☐ Brothers	☐ Grandmother (Maternal)	☐ Grandfather (Maternal)	☐ Grandmother (Paternal)	☐ Grandfather (Paternal)
Kidney Disease	☐ Mother	☐ Father	☐ Sisters	☐ Brothers	☐ Grandmother (Maternal)	☐ Grandfather (Maternal)	☐ Grandmother (Paternal)	☐ Grandfather (Paternal)
Cancer	☐ Mother	☐ Father	☐ Sisters	☐ Brothers	☐ Grandmother (Maternal)	☐ Grandfather (Maternal)	☐ Grandmother (Paternal)	☐ Grandfather (Paternal)
Stroke	☐ Mother	☐ Father	☐ Sisters	☐ Brothers	☐ Grandmother (Maternal)	☐ Grandfather (Maternal)	☐ Grandmother (Paternal)	☐ Grandfather (Paternal)
Other:	☐ Mother	☐ Father	☐ Sisters	☐ Brothers	☐ Grandmother (Maternal)	☐ Grandfather (Maternal)	☐ Grandmother (Paternal)	☐ Grandfather (Paternal)

Health Habits

Tobacco:

Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes _____ packs/day Number of years: _____ Quit date: _____

Vaping:

Do you vape? ☐ Yes ☐ No

Type: ☐ Nicotine ☐ THC ☐ CBD ☐ Flavoring

Alcohol:

Do you drink Alcohol? ☐ Yes ☐ No

How many drinks per week: _____ Number of years: _____ Quit date: _____

Substance Use:

Do you currently use recreational or street drugs? ☐ Yes ☐ No

Comments/type: _____

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