Stepanyan Surgical Arts Center

FACIAL COSMETIC & RECONSTRUCTIVE SURGERY
ORAL & MAXILLOFACIAL SURGERY

PATIENT HEALTH HISTORY

PLEASE NOTE: IT IS: EXTREMELY IMPORTANT THAT YOU BE COMPLETELY TRUTHFUL AND ACCURATE IN COMPLETING THIS HEALTH HISTORY FORM FOR YOUR EXPLICIT HEALTH AND WELL BEING. PLEASE DISCUSS ANY QUESTIONABLE ITEMS PERSONALLY WITH THE DOCTOR. PLEASE ANSWER EACH QUESTION TO THE BEST OF YOUR ABILITY.

		YES	NO
1.	Are you under the routine care of a physician? If so, for what condition(s)	____	____
	_____		
2.	Have you ever been hospitalized or had serious illness? If so, please explain.	____	____
	_____		
3.	Have you ever received a general anesthetic (fully asleep anesthetic)?	____	____
4.	Have you or anyone in your family had an unusual reaction, paralysis, or unexplained fever during anesthesia?	____	____
5.	Have you ever had an injury to your face, jaws, mouth?	____	____
6.	Have you ever had excessive bleeding following dental extractions, surgery or injury, or do you have frequent bruising?	____	____
7.	Do you have excessive snoring while sleeping on your back or waken gasping for air?	____	____
8.	Do you have excessive daytime sleepiness? i.e. fall asleep at work, while driving, or sitting in a quiet place?	____	____
9.	Do you sweat excessively at night during sleep or wake with morning headaches?	____	____
10.	Do you, or have you recently, used tobacco continuously in any form?	____	____
11.	Do you, or have you in the past (5years), used alcoholic beverages in large quantity or excess?	____	____
12.	Do you, or have you in the past (5 years), used any illicit / recreational drugs?	____	____
13.	Do you, or have you in the past (2 years), taken any form of diet pills?	____	____
14.	DO YOU HAVE ANY KNOWN ALLERGIES OR ADVERSE REACTIONS TO MEDICINES? If so, what drugs?	____	____
15.	DO YOU HAVE ANY KNOWN ALLERGIES OR ADVERSE REACTIONS TO LATEX OR OTHER KNOWN MATERIALS?	____	____
16.	DO YOU HAVE ANY KNOWN ALLERGIES OR ADVERSE REACTIONS TO FOODS i.e. eggs, soy? If so, what foods?	____	____
17.	ARE YOU PRESENTLY TAKING ANY MEDICATIONS? If so, please list all medicines including ALL HERBAL DRUGS.	____	____
	_____		
18.	(WOMEN) Are you, or do you suspect that you are pregnant?	____	____
19.	(WOMEN) Do you take oral contraceptives (birth control pills)?	____	____
20.	Do you have any other medical problems or history not yet discussed? If so, please explain?	____	____
	_____		

(Over Please)

21. **DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD, PROBLEMS WITH ANY OF THE FOLLOWING:**

	YES	NO		YES	NO
Heart	____	____			
Lungs	____	____	Hepatitis / yellow jaundice	____	____
Kidneys	____	____	Asthma / Emphysema	____	____
Diabetes	____	____	High Blood Pressure	____	____
Anemia	____	____	Excessive Bleeding / Bruising	____	____
Thyroid	____	____	Cancer	____	____
Seizures	____	____	Glaucoma	____	____
Stroke	____	____	Heart Murmur	____	____
Stomach Ulcers	____	____	Prosthetic (artificial) Joints	____	____
Sickle Cell Disease	____	____	Prosthetic (artificial) Heart Valve	____	____
Tuberculosis	____	____	AIDS / ARC / HIV Positive	____	____
Rheumatic Fever	____	____			

THE ABOVE INFORMATION IS COMPLETELY ACCURATE TO THE BEST OF MY KNOWLEDGE.
IHAVE READ AND UNDERSAND COMPLETELY, ALL OF THE PREVIOUSLY STATED QUESTIONS.

Patient / Guardian Signature_____**Date:**_____

Patient / Guardian Name (please print) _____**Relationship**_____

PLEASE DO NOT WRITE BELOW THIS LINE
(FOR OFFICE USE)

PMH:_____
_____
_____
_____

PSxH:_____
_____
_____

VS: **BP:** _____ / _____ **Pulse:**_____ **Resp.:**_____ **Weight:**_____**Lbs.** **Height**_____

MEDICATIONS:
_____
_____
_____
_____

ALLERGIES: **NKDA** **PENICILLIN** **ERYTHROMYCIN** **CEPHALEXIN** **CODEINE** **SULFA=S** **ASA** **IODINE** **LATEX**
_____
_____

HABITS: **Tobacco** _____**PPD/PPWK/PPM X** _____**Years** **NONE**_____**PRESENT**_____**PAST**_____**QUIT S/P** _____**Months / Years**
_____**CIGS / DAY / WEEK / MONTH**_____**CIGARS / PIPE / SNUFF; per DAY / WEEK / Month**

ETOH: _____ **NONE**_____**PRESENT**____**PAST**_____**QUIT S/P**_____ **Months / Years**
Rec. Drugs: _____ **NONE**_____**PRESENT**____**PAST**_____**QUIT S/P**_____**Months / Years**

Reviewed:

Date: _____ **Date:** _____ **Date:** _____

_____ _____ _____
Assistant / Nurse **Assistant / Nurse** **Assistant / Nurse**

_____ _____ _____
Dr. Martin Stepanyan **Dr. Martin Stepanyan** **Dr. Martin Stepanyan**