Medical History

Please fill out this form as completely as you can. The scope of surgery includes the diagnosis and treatment of disease, injuries and defects involving the functional and esthetic aspects of the tissues in the oral and maxillofacial regions.Health problems may effect outcome of treatment. Incorrect or withheld information can be dangerous to your health. If you have any question, we would be glad to help you. Your information is for our office only and will be kept confidential.

Name:_____ Date:_____

Reason for today's office visit? _____

Are you having any pain? **[ ] Yes [ ] NO** Age _____ Height_____Weight _____

Are you currently under the care of a physician? **[ ] Yes [ ] NO** If yes, what are you being treated for?

_____

Your Physician's Name: _____Phone #_____Last visit_____

List or provide a list of all current medications include herbal or homeopathic remedies.

_____

_____

1. Do you take **BLOOD THINNERS** (anticoagulants ie. Coumadin, Plavix, Aspirin,) [ ] **YES** [ ] **NO**
2. Have you **EVER** taken bisphosphonate medications for osteoporosis/osteopenia such as Fosamax, Boniva, Actonel, Reclast or Prolia? [ ] Yes [ ] NO If, yes which one and for how long? _____
   Have you ever taken bone replacement drugs/chemotherapy used in multiple myeloma and other bone cancers such as Zometa and Aredia? [ ] Yes [ ] NO If yes , which one and how long?_____
3. Have you ever taken steriods (i.e.predniosne), diet pills (such as Fen-Fen) [ ] Yes [ ] No
4. Are you allergic to any of the following: **[ ] No Known Drug Allergies (NKDA)**

   [ ] Aspirin [ ] Codeine or other narcotics [ ] Local Anesthetics [ ] Penicillin/Amoxicillin

   [ ] other antibiotics [ ] Latex [ ] Eggs/Yolk/Soybeans [ ] Sulfites [ ] Tranquilizers/Valium

   Other allergies, please list _____
5. Have you had any illness, operation or been hospitalized in the past 5 years? [ ]Yes [ ] NO
   If yes , please describe _____
6. Have you taken or been told you need antibiotic premedication prior to dental treatment? [ ] Yes [ ] NO
7. Do you smoke or chew tobacco? [ ] Yes [ ] NO If yes, how much per day? _____ and for how long? _____
8. Did you smoke in the past? [ ] Yes [ ] NO If yes, when did you quit? _____
9. Do you drink Alcohol ? [ ] Yes [ ] NO I yes, how much per day or week ? _____
10. Do you use recreational drugs? This is ask for safety with anesthesia [ ] Yes [ ] NO if yes, list_____
11. Have you ever used cocaine? This is ask for safety with anesthesia [ ] Yes [ ] NO if yes, when? _____
12. Have you or a family member EVER had trouble with Anesthesia? [ ] Yes [ ] NO if yes, please describe:_____

13. Please check box if you had or are now having any of the following:

[ ] High Blood Pressure [ ] Chest Pain [ ] Prosthetic heart valves
[ ] Shortness of breath [ ] Heart murmur [ ] Rheumatic fever

[ ] Mitral valve prolapse [ ] Pacemaker [ ] Irregular heart beat/Atrial Fibrillation (A-Fib)
[ ] Heart attack [ ] Heart Catheterization [ ] Heart Surgery [ ] Transfusion

[ ] Respiratory disease [ ] Asthma [ ] Bronchitis [ ] Malignant hyperthermia
[ ] Chronic cough [ ] Emphysema [ ] Hay fever [ ] Sinus Trouble

[ ] Sleep Apnea [ ] Tuberculosis
[ ] Anemia [ ] Hemophilia [ ] Blood disease [ ] Excessive bleeding

[ ] Hepatitis [ ] Jaundice [ ] HIV [ ] Herpes [ ] STD
[ ] Headaches [ ] Fainting [ ] Kidney disease [ ] Dialysis

[ ] Gallbladder [ ] Liver disease [ ] Thyroid disease [ ] Diabetes: [ ] type 1 or [ ] type 2
[ ] Cancer [ ] Radiation [ ] Chemotherapy [ ] Resective cancer surgery

[ ] Arthritis [ ] Neck/Back problems [ ] Grinding or clinching of teeth [ ] Pain/popping/clicking of jaw joint
[ ] History of TMJ treatment [ ] Any previous bad experience or problem with dental treatment

[ ] Artificial joints (i.e. Hip/Knee) - Date of surgery_____

[ ] Epilepsy [ ] Seizure [ ] Glaucoma [ ] Deafness [ ] Anxiety/Mental health problems
[ ] Stress [ ] Skin rash [ ] stroke [ ] Psychiatric treatment

14. Do you have any other conditions not listed above?_____

15. Is there anything you would like to discuss in private with the doctor? [ ] Yes [ ] NO

For Female Patients Only

1. Are you pregnant, or do you think there is a chance you may be pregnant? [ ] Yes [ ] NO
   If yes, how far along are you? _____
2. Are you Nursing? [ ] Yes [ ] NO

If you are using oral contraceptives, it is important that you understand that antibiotics may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete health history to assist the doctor in providing the best possible care. I have read and understand the above information.

_____

Patient/Guardian Signature Date

Print Name:_____

For Office Use Only: _____ _____ _____ _____

Reviewer **Date** **Dr. Initial** **Date**