THE Maxillofacial Surgery CENTER

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Medical History Form

Name: _____ Date:_____

Date of birth: _____ Sex: Male/ Female Height:_____Weight:_____

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

1. Are you in good health?..... Yes ☐ No ☐
2. Have there been any changes in your health in the past year? Yes ☐ No ☐
3. My last physical exam was: _____/_____
4. Are you now under the care of a physician?..... Yes ☐ No ☐
   For what condition? _____
5. The name and address of my physician:

   _____

   _____
6. Do you or have you had any of the following diseases or problems?
   a. Damaged or artificial heart valves or heart murmur…… Yes ☐ No ☐
   b. Rheumatic heart disease Yes ☐ No ☐
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis, or any other heart condition…… Yes ☐ No ☐
      1. Chest pain upon exertion Yes ☐ No ☐
      2. Shortness of breath after mild exercise…… Yes ☐ No ☐
      3. Do your ankles swell Yes ☐ No ☐
   d. Allergies…….. Yes ☐ No ☐
   e. Sinus trouble Yes ☐ No ☐
   f. Asthma or hay fever …….. Yes ☐ No ☐
   g. Fainting spells or seizures Yes ☐ No ☐
   h. Diabetes…….. Yes ☐ No ☐
   i. Hepatitis, jaundice or liver disease Yes ☐ No ☐
   j. Frequent or recurring mouth sores…… Yes ☐ No ☐
   k. Thyroid problems Yes ☐ No ☐
   l. Respiratory problems, emphysema, bronchitis, etc…….. Yes ☐ No ☐
   m. Arthritis or painful, swollen joints including jaw joint (TMJ) Yes ☐ No ☐
   n. Stomach ulcer or hyperactivity…… Yes ☐ No ☐
   o. Kidney trouble Yes ☐ No ☐
   p. Persistent cough or cough that produces blood……. Yes ☐ No ☐
   q. Tuberculosis Yes ☐ No ☐
   r. Persistent swollen neck glands…… Yes ☐ No ☐
   s. Low blood pressure Yes ☐ No ☐
   t. Epilepsy or neurological disorder…….. Yes ☐ No ☐
   u. Are you taking vitamins or homeopathic remedies Yes ☐ No ☐
   v. Cancer …… Yes ☐ No ☐
   w. A disease, drug or transplant that depresses your immune system Yes ☐ No ☐
7. Are you wearing contact lenses? Yes ☐ No ☐
8. Are you wearing removable dental appliances (bridge, partial, etc.)? Yes ☐ No ☐
9. Have you ever had treatment for a tumor or growth? Yes ☐ No ☐

Medical History is continued on back page…

Continuation of Medical History Form…

10. Are you allergic to or have you had a reaction to:
    a. Local anesthetics…… Yes ☐ No ☐
    b. Penicillin or antibiotics Yes ☐ No ☐
    c. Sulfa drugs…….. Yes ☐ No ☐
    d. Barbituates or sleeping pills Yes ☐ No ☐
    e. Aspirin…… Yes ☐ No ☐
    f. Iodine Yes ☐ No ☐
    g. Codeine or other narcotics…… Yes ☐ No ☐
    h. Latex (exam gloves) Yes ☐ No ☐
    i. Other: Please List:_____ Yes ☐ No ☐
11. Have you had any serious trouble associated with previous dental treatment? Yes ☐ No ☐
12. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, for osteoporosis, chemotherapy for multiple myeloma, etc.)? Yes ☐ No ☐
13. Any serious illness, operation or hospitalization in the last 5 years?..... Yes ☐ No ☐
14. Have you had abnormal bleeding?..... Yes ☐ No ☐
    a. Have you ever required a blood transfusion? Yes ☐ No ☐
15. Do you have any blood disorder such as anemia?..... Yes ☐ No ☐
16. Do you snore, wake up multiple times at night, feel unrested in the morning or have sleep apnea? Yes ☐ No ☐
17. Do you wish to talk with doctor privately about anything? …… Yes ☐ No ☐
18. Are you taking any prescription or non-prescription medications? Yes ☐ No ☐
    If so, please list _____
19. Do you have any other condition or disease the doctor should know about? Yes ☐ No ☐
    If so, explain: _____
    _____

Women

19. Are you pregnant or trying to become pregnant? Yes ☐ No ☐
20. Do you have problems associated with your menstrual cycle? Yes ☐ No ☐
21. Are you taking birth control pills? Yes ☐ No ☐

Chief Dental Complaint: _____
_____

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

Patient's signature: _____ **Date:** _____
_____

HIPPA ACKNOWLEDGEMENT

Patient Acknowledgement

I have reviewed, understand, and agree to the content of the Notice of Privacy Practices.

Patient Signature_____
_____

Doctor notes:

PMH:

ROS:

MEDS:

ALL:

PSXH:

PSOCH:

FH: