

Stateline Oral & Maxillofacial Surgery, PC

MEDICAL HISTORY FORM

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex: M / F

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

For the following questions, 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. Has there been any change in your health in the past year? Yes No
If so, please explain:
3. Are you now under the care of a physician? Yes No
If yes, for what condition?

The name and address of my physician is:

Please list the date of your last physical examination: \_\_\_\_\_

- 4. Have you had any serious illness, significant operation or hospitalization within the past 5 years? Yes No
5. Do you take blood thinning medications? Yes No
6. Are you taking any medications? Yes No
(this would include all non-prescription, homeopathic or "natural" remedies including diet pills)

If Yes, Please list ALL medications:

- 7. Are you allergic to any medication? Yes No
If so, please identify your medication allergies:
a. Local anesthetics Yes No
b. Penicillin or antibiotics Yes No
c. Sulfa drugs Yes No
d. Barbiturates or sleeping pills Yes No
e. Aspirin Yes No
f. Iodine Yes No
g. Codeine or other narcotics Yes No
h. Latex or rubber products Yes No
i. Other, please list:

- 8. Do you have or have you had any of the following diseases or problems?
a. 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
b. Seasonal, environmental or food allergies Yes No
c. Sinus trouble Yes No
d. Asthma or hay fever Yes No
e. Fainting spells or seizures Yes No
f. Diabetes Yes No
g. Hepatitis, jaundice or liver disease Yes No
h. Frequent or recurring mouth sores Yes No
i. Thyroid problems Yes No
j. Respiratory problems, emphysema, bronchitis, etc. Yes No
k. Arthritis or painful, swollen joints including jaw joint (TMJ) Yes No
l. Stomach ulcer or hyperacidity Yes No
m. Kidney disease Yes No
n. Tuberculosis Yes No

- o. Persistent cough or cough that produces blood..... Yes No
  - p. Persistent swollen neck glands..... Yes No
  - q. Low blood pressure..... Yes No
  - r. Epilepsy or neurological disorder ..... Yes No
  - s. Are you taking vitamins or homeopathic remedies ..... Yes No
  - t. History of cancer..... Yes No
  - u. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No
9. Do you have an artificial (implanted) joint? ..... Yes No

**If so, please list the joint with the date of surgery:**

- 10. Have you had abnormal bleeding?..... Yes No
- 11. Do you have any blood disorder such as anemia?..... Yes No
- 12. Have you ever had treatment for a tumor or growth?..... Yes No
- 13. Do you smoke? ..... Yes No  
If so, please check # of packs per day and list years of smoking: O one O two O three packs per day for \_\_\_\_\_ years
- 14. Have you had any serious trouble associated with previous dental treatment? ..... Yes No  
If so, explain:

- 15. Do you have any other condition or disease you think the doctor should know about? ..... Yes No  
If so, explain:

- 16. Are you wearing contact lenses?..... Yes No
- 17. Are you wearing removable dental appliances?..... Yes No
- 18. Do you wish to talk with the doctor privately about anything?..... Yes No

**Women**

- 19. Are you pregnant or trying to become pregnant..... Yes No
- 20. Do you have problems associated with your menstrual period? ..... Yes No
- 21. Are you nursing?..... Yes No
- 22. 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, about the inquiries set forth above have been answered to my satisfaction. I will not hold the surgeon, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: \_\_\_\_\_ Patient's / Guardian's Signature: \_\_\_\_\_

**FOR COMPLETION BY THE DOCTOR**

Comments on patient interview concerning medical history:

Anesthesia Risk Assessment: ASA I II III

Date: \_\_\_\_\_ Doctor's Signature: \_\_\_\_\_

Medical History Updates:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____