

TRI-STATE ORAL & FACIAL SURGERY

MEDICAL HISTORY FORM

Name: _____ Chart # (Office use): _____

Date: _____ 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
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? Yes No
If so, for what condition? _____
5. The name and address of my physician is: _____

6. Have you had any serious illness or hospitalization within the past 5 years? Yes No
7. Have you had any significant operation(s) or procedures requiring sedation or general anesthetic? Yes No
If so, please list _____
8. Do you have or have you had any of the following diseases or problems?
 - a. Damaged heart valves, artificial 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. Sinus trouble or hay fever Yes No
 - e. Respiratory problems, emphysema, bronchitis, asthma, etc. Yes No
 - f. Liver disease, hepatitis, jaundice Yes No
 - g. Kidney disease Yes No
 - h. Diabetes Yes No
 - i. Pancreatic disease Yes No
 - j. Stomach ulcers, acid reflux, or colitis Yes No
 - k. Thyroid disease, goiter Yes No
 - l. Glaucoma Yes No
 - m. Seizures, convulsions, epilepsy, psychiatric treatment or other nervous disorder Yes No
 - n. Bleeding disorder, anemia, bleeding tendency or blood transfusion Yes No
 - o. Arthritis Yes No
 - p. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth Yes No
 - q. Implants (Heart Valve, Pacemaker, Hip, Knee) Yes No
 - r. Cancer Yes No
 - s. Radiation (X-ray treatment for cancer) in head and neck region Yes No
 - t. Chemotherapy for the treatment of cancer Yes No
 - u. Any disease, drug or transplant operation that has depressed your immune system Yes No
 - v. Recurrent infections of any kind Yes No
 - w. Recurrent mouth ulcers Yes No

PLEASE CONTINUE TO THE NEXT PAGE

9. ARE YOU TAKING OR USING ANY OF THE FOLLOWING:

- | | | |
|---|-----|----|
| a. Antibiotics? | Yes | No |
| b. Anticoagulants (Blood Thinners)? | Yes | No |
| c. Aspirin or drugs such as Motrin, Ibuprofen, or Aleve | Yes | No |
| e. High Blood Pressure medications? | Yes | No |
| f. Steroids? | Yes | No |
| h. Insulin or Oral Anti-Diabetic drugs? | Yes | No |
| i. Tranquilizers? | Yes | No |
| j. Weight reduction pills or diet aids? | Yes | No |
| k. Vitamins, Herbal remedies (ginko biloba, ephedra, ginseng, etc.) or other supplements? | Yes | No |

Please list all current medication (or provide a copy): _____

10. Are you allergic to or have you had a reaction to:

- | | | |
|---|-----|----|
| a. Local anesthetics | Yes | No |
| b. Penicillin, Amoxicillin, Cephalosporins or Sulfa medications | Yes | No |
| c. Other antibiotics | 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/Foods (eggs, soybeans, etc.) | Yes | No |

12. Have you had any serious trouble associated with previous dental treatment? Yes No
If so, explain: _____

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

14. Do you smoke or chew tobacco? If so, how much per day and for how long: _____

15. Do you wish to talk with the doctor privately about anything? Yes No

FEMALES ONLY

16. Are you pregnant or is there any chance you might be pregnant? Yes No

17. Are you nursing? Yes No

18. Are you taking birth control pills? Yes No

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) 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 or other medication is completed. Please consult with our physician for further guidance.

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 my dentist, 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 Signature: _____