Centre Oral & Facial Surgery, P.C. — Medical History Form

Name: _____ **Today's Date**: _____

Date of Birth: _____ **Sex: M / F** **Height**: _____ **Weight:** _____

What is the reason for your visit today? _____

ANSWER THE FOLLOWING QUESTIONS AS BEST AS YOU CAN. Your responses are confidential and for our records only. Do not answer any question that you do not understand.

1. **MEDICAL CONDITIONS -** Do you have a history of the following diseases or health issues. **(CIRCLE ALL THAT APPLY)**

Damaged Heart Valves	Artificial Heart Valves	Heart Murmur	Rheumatic Fever
Rheumatic Heart Disease	High Blood Pressure	Heart Trouble	Heart Attack
Angina / Chest Pain	Congestive Heart Failure	Arteriosclerosis	Pacemaker
Stroke / Mini Stroke (TIA)	Asthma	Persistent Cough	Anemia
Chronic Sinus Trouble	Emphysema / COPD	Seasonal Allergies	Diabetes
Fainting Spells	Low Blood Pressure	Depressed Immune System	Glaucoma
Cataracts	Fever Blisters / Mouth Ulcers	Seizures / Epilepsy	Neurological Disorder
Osteoporosis	Rheumatoid Arthritis	Osteoarthritis	Thyroid Problems
Hepatitis / Jaundice	Liver Disease	Stomach Ulcer	Hyperacidity
Kidney Trouble / Dialysis	Bleeding Disorder	Dry Mouth / Sjogren's Disease	Connective Tissue Disease
Bone Disease	Depression	Anxiety	Attention Deficit Disorder
Poor Hearing	Ringing in the Ears / Tinnitus	Dizziness / Vertigo	Poor Vision

OTHER MEDICAL CONDITIONS - List any ***current and past*** medical conditions not referenced above:

_____ _____

_____ _____

2. **HEALTH STATUS** – Have there been **changes in your health status within the last 12 months** (i.e., worsening of a medical condition, hospitalization or operation) or are you currently being treated or evaluated for **a new medical condition** ..... Yes No
If yes, please describe: _____

_____

3. **SURGERIES** – List all major surgeries you have had:

_____ _____ _____

_____ _____ _____

4. **MEDICATIONS -** LIST ALL CURRENT prescription, non-prescription, vitamin supplements, homeopathic herbal or natural remedies, and diet pills. ***Include dosage* and *frequency*** to the best of your ability. If you have an *accurate*, *up-to-date* list, provide a copy.

_____ _____

_____ _____

_____ _____

_____ _____

PREFERRED PHARMACY: _____ **LOCATION:** _____

5. **ALLERGIES** - Are you allergic to or have you had an **adverse reaction** to:
   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 or Ibuprofen ..... Yes No
   f. Iodine ..... Yes No
   g. Codeine or other narcotics ..... Yes No
   h. Latex or rubber products ..... Yes No
   i. Chemicals or Jewelry (rash or sensitivity) ..... Yes No
   j. Other or additional allergies or reactions (**please describe below**) ..... Yes No

_____

6. Are you taking or have you ever taken **Fosamax**, **Actonel, Boniva, Reclast, Skelid, Didronel, Aredia, Zometa** or other drug(s) to treat *osteoporosis, multiple myeloma, or cancer*? ..... Yes No

7. Have you been told that you are a **heavy snorer** or have been diagnosed with **sleep apnea**?..... Yes No

8. Are you currently being treated for jaw joint **(TMJ) or facial pain** conditions?..... Yes No

9. Do you have **clicking or popping of the jaw joint** or difficulty opening your mouth?..... Yes No

10. Do you **grind or clench** your teeth or **wake up with sore jaws**?..... Yes No

11. Do you have **a neck injury or neck pain**?..... Yes No

12. Have you ever had **joint replacement surgery** such as a hip, knee or other joint? ..... Yes No

13. Have you had surgery to **bypass, replace or repair major blood vessels** in your arms or legs..... Yes No

14. Have you ever had **cancer** or treatment for a tumor or growth?..... Yes No

15. *Other than routine x-rays*, have you ever been treated with **radiation to the head and / or neck region**? ..... Yes No

16. Do you **smoke or use chewing tobacco**? ..... Yes No
    If yes, how many packs cigarettes or cans of chew per day? _____ for how many years? _____

17. Do you **drink alcohol**?..... Yes No
    If yes, how frequently? _____

18. Do you have or have had any **chemical dependency to substances** such as alcohol, "recreational drugs" (Marijuana, cocaine, heroin, etc.) prescription drugs or narcotic pain pills? ..... Yes No

19. Are you, or have you been, in a **drug or alcohol recovery program**? ..... Yes No

20. Have you had any **serious trouble associated with previous anesthesia, medical or dental treatments**? ..... Yes No
    If yes, explain: _____
    _____

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

22. Are you wearing **contact lenses**?..... Yes No

23. Are you wearing **removable dental appliances**? ..... Yes No

24. Do you have **Advanced Directives** / Living Will? ..... Yes No
    Advanced Directives information is available upon request. This facility does not honor Advanced Directives.

WOMEN ONLY

25. Are you **pregnant or trying to become pregnant?** ..... Yes No

26. Do you have **problems associated with your menstrual period**? ..... Yes No

27. Are you **nursing**?..... Yes No

28. Are you taking **birth control pills**? ..... Yes No

I understand the information I provided on this form is essential to determine my medical and dental needs and the provision of treatment. I understand that any changes in my health must be reported to the office as soon as possible. I have read and understand these questions and answered them all truthfully and to the best of my ability. I will not hold Centre Oral & Facial Surgery, P.C., or any staff member, responsible for errors or omissions I have made in the completion of this form.

Patient or Guardian Signature: _____ Date: _____

If you are a guardian, please describe your relationship to the patient: _____

Doctor Signature: _____ Date: _____