Oral & Maxillofacial Surgical Specialists, P.C.

Date:
Chart #
Doctor #

Medical History

Patient Name:	Age:	Male or Female?	Ht:	Wt:

Referred By:	Personal Dentist:	Primary Care Physician:

Please give the name, address and phone number of a person outside your household who could help us in contacting you.

Have you or any members of your family been treated by our practice? Please list:

Why did you come to our office? What do we need to help you with?

List the surgeries that you have had:

Did you have general anesthesia?

What medicines are you allergic to?
Penicillin Aspirin Demerol Codeine Sulfa Others?

Other allergies…peanuts, eggs, latex, etc?

Question		
Are you presently taking blood thinners, such as: Aspirin, Plavix, Lovenox, Coumadin/Warfarin	Yes	No
Have you ever been treated for osteoporosis and used bisphosphonate meds (Skelia, Fosomax, Didronel, Boniva, Actonel, Aredia, Zometia, etc.)?	Yes	No
Do you drink alcohol?	Yes	No
Do you currently use, or have you ever used or abused drugs?	Yes	No
Family history of bleeding or anesthetic reactions?	Yes	No
Are you being treated by a physician for any illness?	Yes	No
Do you wish to talk to the doctor privately?	Yes	No
Have you ever had radiation treatment to your head or neck?	Yes	No

Do you or have you had any of the following?

Condition		
Rheumatic Fever	Yes	No
High Blood Pressure	Yes	No
Stroke	Yes	No
Heart Disease (heart attack, murmur,valve replacement, bypass surgery, stents)	Yes	No
Lung Disease (asthma, emphysema, TB)	Yes	No
Kidney Disease	Yes	No
Liver Disease (hepatitis, jaundice, cirrhosis)	Yes	No
Epilepsy or Seizures	Yes	No
Arthritis	Yes	No
Mental Illness / Handicap	Yes	No
Fever Blisters	Yes	No
TMJ (jaw joint) Problems	Yes	No
Bleeding Disorders	Yes	No
Have you ever had a blood transfusion?	Yes	No
Have you had a hip or joint replacement?	Yes	No
Do you smoke cigarettes, cigars, pipes or use smokeless tobacco?	Yes	No
Gastrointestinal Disease (ulcers, colitis, diverticulitis)?	Yes	No
Ladies -- Are you pregnant?	Yes	No
Do you snore or have sleep apnea?	Yes	No
Do you require any premedications before any surgical or dental procedure?	Yes	No
Any Herbal Remedies being used?	Yes	No
Are you a diabetic?	Yes	No
Have you ever been diagnosed with cancer?	Yes	No
Do you have "Restless Leg Syndrome"?	Yes	No
ASA Classification: I II III IV	Doctors' use	

List medications you are currently taking and why you are taking them:

I understand the information I have provided on this form is essential to determine my surgical needs and that I have answered all questions truthfully.I will report any changes in my health history as soon as possible.

Signature (Parent or Guardian): Date: OMSS:

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