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

Name: _____ Today's Date: _____

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

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

1. Please list all *current and past* **MEDICAL** conditions: _____
   _____
   _____
2. Please list all major **SURGERIES** that you have had: _____
   _____
   _____
3. Do you have or have you had any of the following diseases or problems? (**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

4. Has there been any **recent (within the last 12 months) changes in your health status** such as worsening of a medical condition, hospitalization or operation? ..... Yes No
   If so, please describe: _____
   _____
5. Are you currently being **treated or evaluated for a new medical condition**?..... Yes No
   If so, please describe: _____
6. **PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING.** PLEASE INCLUDE all **non-prescription**, **homeopathic herbal or "natural" remedies including diet pills.** Be sure to include *dosage* and *how often* you take each medication to the best of your ability. **If you have an *accurate* and *up to date* written or typed list, please provide us with a copy.**
   _____
   _____
   _____
7. 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
   _____
   _____

8. 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

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

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

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

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

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

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

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

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

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

18. 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? _____

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

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

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

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

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

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

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

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

Women

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

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

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

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

What is the reason you are seeking treatment at Centre Oral & Facial Surgery, P.C.?

_____

_____

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 you relationship to the patient:_____

Doctor Signature:_____ Date:_____