Oral & Facial Surgeons of Michigan

MEDICAL HISTORY FORM

Name: _____ Date: _____

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

For the following questions, please circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1) Has there been any change in your health in the past year? ..... YES NO
2) My last physical exam was on _____/_____/_____
3) Are you now under the care of a physician? ..... YES NO
   If so, for what condition? _____
4) The name, address and telephone of my physician is: _____
   _____
5) Have you had any serious illness, operation or hospitalization within the past 5 years? ..... YES NO
   (If so, please detail) _____
6) Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... YES NO
7) Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia or Zometa)? ..... YES NO
8) Are you taking any of the following:
   a) Antibiotics? ..... YES NO
   b) Anticoagulants (blood thinners)? ..... YES NO
   c) Aspirin or drugs such as Motrin, Aleve, ibuprofen? ..... YES NO
   d) High blood pressure medications? ..... YES NO
   e) Steroids (Cortisone, etc)? ..... YES NO
   f) Tranquilizers? ..... YES NO
   g) Insulin or Oral Anti-diabetic drugs? ..... YES NO
   h) Digitalis, Inderal, Nitroglycerin or other heart medication? ..... YES NO
   i) Please list any and all medications taken, including prescription medicine(s),diet pills, non-prescription, over-the-counter medications, vitamins, homeopathic or natural remedies, herbal medications or supplements? ..... YES NO
   If so, please list: _____
   _____
9) Are you allergic to or have you had a reaction to:
   a) Local anesthetics ..... YES NO
   b) Penicillin, sulfa or other antibiotics ..... YES NO
   c) Barbiturates or sleeping pills ..... YES NO
   d) Aspirin ..... YES NO
   e) Iodine ..... YES NO
   f) Codeine or other narcotics ..... YES NO
   g) Other Drugs (If so, please list) _____ YES NO
   h) Latex or other rubber products ..... YES NO
   i) Food allergies (If so, please list) _____ YES NO
   j) Allergies (Enviromental) ..... YES NO
10) Do you have or have you had any of the following diseases or problems?
   a) Damaged heart valve, 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 (Please circle all that apply) ..... 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 ..... YES NO
   e) Fainting spells or seizures ..... YES NO

f) Diabetes ..... YES NO
g) Hepatitis, jaundice or liver disease ..... YES NO
h) Thyroid problems ..... YES NO
i) Respiratory problems, emphysema, bronchitis, asthma, COPD (Please circle all that apply) ..... YES NO
j) Arthritis or painful, swollen joints including jaw joint (TMJ) ..... YES NO
k) Osteoporosis ..... YES NO
l) Stomach ulcer, hyperacidity or reflux (G.E.R.D.) ..... YES NO
m) Kidney trouble ..... YES NO
n) Tuberculosis ..... YES NO
o) Persistent cough or cough that produces blood ..... YES NO
q) Persistent swollen neck glands ..... YES NO
r) Low blood pressure ..... YES NO
s) Epilepsy, seizures or neurological disorder ..... YES NO
t) Cancer ..... YES NO
u) Any disease, drug or transplant operation that has depressed your immune system ..... YES NO

11) Have you had abnormal bleeding? ..... YES NO
a) Have you ever had a blood transfusion? ..... YES NO
12) Do you have any blood disorder such as anemia? ..... YES NO
13) Have you ever had treatment for a tumor or growth? ..... YES NO
14) Have you had radiation therapy to head, neck or jaws? ..... YES NO
15) Do you have any other condition or disease you think the doctor should know about? ..... YES NO
(If so, please explain) _____
_____
16) Do you smoke or chew tobacco? ..... YES NO
How much?
17) Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide? ..... YES NO
(If so, please explain) _____
_____
18) Do you wish to talk with the doctor privately about anything? ..... YES NO

<u>WOMEN</u>

19) Are you pregnant or trying to become pregnant? ..... YES NO
20) Are you nursing? ..... YES NO
21) Are you taking oral contraceptives? ..... YES NO

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: _____ Patient or guardians signature _____

Doctor notes: _____

_____

_____

_____

Reviewed By: _____ Date: _____