ORAL & FACIAL SURGERY CENTER

MEDICAL HISTORY

Patient Name ______________________ Today's date ______________

1.) Have you had any serious illness or operation? Yes / No

If yes, please describe

2.) Have you been under the care of a physician recently? Yes / No Date of last medical care

If yes, please describe

3.) Have you ever had a blood transfusion? Yes / No Please provide approximate dates

4.) Have you or anyone in your family ever had an unfavorable reaction to any local or general anesthetic? Yes / No

5.) Family History: Please list any significant family health problems

6.)Women Only Are you pregnant? Yes / No Are you nursing? Yes / No Are you taking birth control pills? Yes / No

PLEASE (X) YES, IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

Yes	No		Yes	No		Yes	No	
[ ]	[ ]	AIDS	[ ]	[ ]	Epilepsy	[ ]	[ ]	Psychiatric Care
[ ]	[ ]	Anemia	[ ]	[ ]	Fainting	[ ]	[ ]	Radiation Treatment
[ ]	[ ]	Arthritis, Rheumatism	[ ]	[ ]	Glaucoma	[ ]	[ ]	Respiratory Disease
[ ]	[ ]	Artifical Valve	[ ]	[ ]	Headache	[ ]	[ ]	Rheumatic Fever
[ ]	[ ]	Asthma	[ ]	[ ]	Heart Murmur	[ ]	[ ]	Scarlet Fever
[ ]	[ ]	Back Problems	[ ]	[ ]	Heart Problems	[ ]	[ ]	Shortness of Breath
[ ]	[ ]	Blood Disease	[ ]	[ ]	Hemophilia	[ ]	[ ]	Skin Rash
[ ]	[ ]	Cancer	[ ]	[ ]	Hepatitis	[ ]	[ ]	Stroke
[ ]	[ ]	Chemical Dependency	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Swelling of Ankles/Feet
[ ]	[ ]	Chemotherapy	[ ]	[ ]	HIV Positive	[ ]	[ ]	Thyroid Problems
[ ]	[ ]	Circulatory Problems	[ ]	[ ]	Jaw Pain	[ ]	[ ]	Tobacco Habit
[ ]	[ ]	Cortisone Treatments	[ ]	[ ]	Kidney Disease	[ ]	[ ]	Tonsillitis
[ ]	[ ]	Cough, Persistent	[ ]	[ ]	Mitral Valve Prolapse	[ ]	[ ]	Tuberculosis
[ ]	[ ]	Coup Up Blood	[ ]	[ ]	Nervous Problems	[ ]	[ ]	Ulcer
[ ]	[ ]	Diabetes	[ ]	[ ]	Pacemaker	[ ]	[ ]	Venereal Disease

MEDICATIONS

Please list medications you are currently taking:

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ALLERGIES

[ ] Aspirin

[ ] Barbiturates (Sleeping Pills)

[ ] Codeine

[ ] Local Anesthetic

[ ] Iodine

[ ] Penicillin

[ ] Sulfa

[ ] Latex

[ ] General Anesthesia

Other ______________________

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The above information is accurate and complete to the best of my knowledge. I will not hold my doctor or his staff responsible for any errors or omissions that I may have made in the completion of this form. I give my permission for my doctor to take any necessary X-rays, photos or study models to enable complete diagnosis and treatment.

Patient or responsible parent's signature ______________________ Date ______________