MEDICAL HISTORY First Name_____M.I.____Last Name_____DOB:_____

To our patients: Although oral surgeons primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

*** IF YOU ARE HAVING A GENERAL ANESTHETIC, PLEASE ANSWER QUESTION #1**

1) Have you ever had general anesthesia (gone to sleep for surgery)? YES NO
   Did you have an adverse reaction? **Y**__ **N**__**NA**__If yes, please explain_____
   *** Current weight for anesthesia purposes**_____
   *** If you are having surgery with a general anesthetic today,**
   Have you had anything to eat or drink in the last 6 hours? YES NO
   *** Who is driving you home today?**_____

2) Have you been a patient in the hospital or emergency room during the last five years? YES NO

3) Are you currently under the care of a physician? YES NO
   If yes, please explain_____

4) Please list any medications you are **currently** taking (including blood thinners)

MEDICATION:		**LAST DOSE TAKEN AT:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5) Because of serious adverse reactions with anesthetic agents, have you used cocaine, marijuana, amphetamines (speed) or any other mood altering drugs? YES NO

6) Are you allergic to any medications? Penicillin Codeine Sulfa Aspirin Latex Other_____

7) Have you ever had any excessive bleeding requiring special treatment? YES NO

8) **WOMEN:** Are you pregnant now? YES NO

CIRCLE any of the following which you have had or have at the present time:

Heart Failure	Anemia	Chemical Dependency	Smoking/Chewing Tobacco
Heart Attack(s)	Hemophilia	Sickle Cell Disease	Emphysema
Angina Pectoris/Chest Pain	Bruise Easily	Stomach Ulcers	Allergies
Stroke	Arthritis	Kidney Trouble/Dialysis	Asthma
Heart Murmur	HIV/AIDS	Cancer/Leukemia	Cough/Bronchitis
Rheumatic Fever	Artificial Joint	Radiation Therapy	Sinus Trouble
Mitral Valve Prolapse	Pain in Jaw Joints	Chemotherapy	Hayfever
Heart Surgery	Cortisone Medication	Blood Transfusion	Tuberculosis
Heart Pacemaker	Epilepsy/Seizures	Hepatitis/Liver Disease	Cold Sores
Irregular Heart Beat	Psychiatric Treatment	Purpura	Fainting/Dizzy Spells
Artificial Heart Valve	Diabetes	Bone Density Medications/	Snoring/Sleep Apnea
Congenital Heart Problems	Thyroid Disease	Bisphosphonates	Malignant Hyperthermia
High Blood Pressure	Blood Thinners		

9) Do you have any disease, condition or problem not listed YES NO
   If yes, please explain_____

AUTHORIZATION

I authorize my surgeon and his/her designated staff to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

_____ /_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE** **Doctor's Signature**

HEALTH HISTORY UPDATES:

Signature of patient, parent or guardian	Reviewed by	Date