Stateline Oral & Maxillofacial Surgery, PC

MEDICAL HISTORY FORM

Patient name: ________________________________ Date:

Date of birth: ____________________ Age _______ Sex: M / F Height: Weight:

Your medical history is important to the treatment you will receive. For the following questions, circle the best answer. Please give written answers when appropriate. Your answers are for our records only and will be considered confidential.

Are you having a problem that brings you into the office today? Yes No
If so, please explain:

Please describe your current health: Excellent Good Fair Poor

Have there been any changes to your general health in the past 2 years? Yes No
If so, please explain:

What is the name of your primary physician?
Date of last office visit: Office location (city):

Have you been hospitalized within the past 2 years?
If so, please explain:

Do you take any prescription medications? If so, please list all medications below:

Do you take any non-prescription medications, remedies, drugs or chemicals? If so, please list all substances:

Please initial: I have listed all prescriptions and substances that I take on an occasional or regular basis above: __________

Are you allergic to?
Eggs or egg products: Yes No
Soy, soy beans or soy products: Yes No
Peanut, nuts or nut products: Yes No
Latex or latex products: Yes No

Are you allergic to any prescription or non-prescription medication? Yes No
If so, please list all medication allergies:

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia and /or intravenous sedation? If so, please describe:

Do you have or have you ever had:
Any form of heart problem? Yes No
If so, please describe:

Do you have or have you had any form of breathing problem? Yes No
If so, please describe:

Do you have implants anywhere in the body? Yes No
If so, please list implants with date of surgery:

Have you had radiation to the head and neck region? Yes No
If so, please explain:

Do you have a history of bleeding problems? Yes No
If so, please explain:

Do you have a history of cancer, chemotherapy or transplant operation? Yes No
If so, please explain:

Do you smoke? Yes No
Do you drink any form of alcohol on a regular (daily) basis? Yes No
Have you used an illicit drug in the past week? Yes No

Have you had complications with dental treatment in the past? Yes No
If so, please explain:

Do you have any other condition or disease you think the doctor should know about? Yes No
If so, please describe:

Do you wish to talk to the doctor privately about anything? Yes No

Women:
Are you pregnant, or is there any chance that you might be pregnant? Yes No
Are you nursing? Yes No

CERTIFICATION OF INFORMATION
I understand the importance of a truthful and complete health history to assist the doctor in providing the best and safest care possible. To the best of my knowledge, the above information is complete and correct.

Signature of patient / parent or guardian: Date:
Printed name of patient / parent or guardian:
If not the patient, the relationship to the patient:

FOR COMPLETION BY THE DOCTOR
Comments on patient interview concerning medical history:

Anesthesia Risk Assessment: ASA I II III

Date:_________________________ Doctor’s Signature: ____ 5/2017