semmel oral + facial surgery

MEDICAL HISTORY FORM

Name: _____ Date: _____

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

Why are you here today? _____were you given any antibiotics or pain medicine for this appointment
CHECK ONE *YES or NO*

Do you have or have you had the following diseases or problems? **(CHECK all that apply and then explain)**

Heart Disease: Heart Attack, Chest Pain, Coronary Artery Disease, Heart Surgery, Pacemaker, Defect at Birth, Valve Replacement, Irregular Heart Beat, Congestive Heart Failure, History of Bacterial Endocarditis, Other

_____

Breathing Problems: Asthma, Bronchitis, COPD, Emphysema, Sleep Apnea, Shortness of Breath, Tuberculosis, Other

_____

Vascular: High Blood Pressure, Low Blood Pressure, Stroke, TIA, Hardening of the Arteries, Other

_____

Endocrine: Diabetes (Insulin Dependent or Non-Insulin Dependent), Hypoglycemia, Thyroid problems, Other

_____

Neurologic: Anxiety, Dementia, Epilepsy, Fainting Spells, Headaches, Seizures, Mentally Handicapped, Other

_____

Liver/Kidney Disease: Hepatitis, Jaundice, Dialysis, Kidney Failure, Kidney Stones, Other

_____

Musculoskeletal: Arthritis, Artificial Joint, Fibromyalgia, MS, Osteoporosis, Other

_____

Gastrointestinal: Ulcers, GERD, Colitis, Crohn's Disease, Gastric Bypass, Other

_____

Head and Neck: Chronic Sinusitis, Swollen Glands, Difficulty Swallowing, Glaucoma, Radiation Therapy, TMJ Disorder

_____

Hematologic: Anemia, Bleeding Disorder, Blood Transfusions, Hemophilia, Leukemia, Lymphoma, Other

_____

Cancer: Breast, Prostate, Lung, Mouth, Colon, Skin, Uterine, Other Cancer, Chemotherapy, Radiation

_____

Immune System: HIV, AIDS, Immunosuppressive Drug Therapy (Remicade, Enbrel, Humira), Other

_____

Females: Pregnant, Breast Feeding, other _____

***Are you to take a "PREMED" antibiotic prior to dental treatment by a medical provider (ex: cardiologist, Orthopedist)?** **CHECK ONE** *YES or NO*

If yes, which antibiotic?_____ For what medical condition?_____

***Have you taken the following Bisphosphonate Drugs?** Fosamax, Actonel, Boniva, Reclast, **Zometa, Aredia**

***Do you use tobacco products?** **CHECK ONE** *YES or NO* **If yes, what products and how often?** _____

***Alcohol use: CHECK ONE** ____ None ____Social or Occasional ____Daily

***Do you have a history of Drug Abuse? CHECK ONE** *YES or NO* **Please explain:** _____

***Are you currently under a Pain Management Contract? CHECK ONE** *YES or NO*

If yes, please list your doctor: _____

***Please list ALL previous SURGERIES you have had with SEDATION (ex: colonoscopy) and dates:**

_____

_____

_____

***Did you or any family members have complications following previous surgeries? CHECK ONE** *YES or NO*

Please explain: _____

***Did you have Nausea or Vomiting following previous surgeries? CHECK ONE** *YES or NO*

***Are you allergic to any of the following? (Please check all that apply)**

__ Amoxicillin __ Eggs __ Sulfa Medicines

__ Anesthetics __ Latex __ Sulfites

__ Aspirin __Penicillin __Soy

__Codeine __ Narcotic __Other _____

***Please list all current MEDICATIONS, HERBAL and/or VITAMINS that you are taking:**

_____

_____

_____

_____

_____

Patient (Guardian) Signature:_____ Relationship: _____ Date:_____

Doctor Signature: _____ Date: _____