



ORAL and MAXILLOFACIAL ASSOCIATES
Patient Medical History

Name: _____ Weight: _____ Height: _____ Age: _____ Date of Birth: _____

Name of Physician: _____ Ph: _____ Name of Dentist: _____ Ph: _____

Name of person who referred you to our office: _____ Ph: _____ Are you under a physicians care? Yes No

If so why?: _____ Date of last physical exam _____ Are there any limitations to your activities? Yes No

HAVE YOU EVER HAD ANY OF THE FOLLOWING

- | | | | |
|--|--|-------------------------------------|--|
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack, disease or murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Steroids within the last year | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abnormal EKG | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Valve replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emotional or Psychiatric problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Treatment or counseling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pacemaker/Defibrillator Implant | <input type="checkbox"/> Yes <input type="checkbox"/> No | Peptic Ulcer or stomach disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina or chest pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Porphyria (blood disease) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema or other lung disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Complications with tooth extraction | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia, Sickle Cell trait/disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant or nursing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding tendency or prolonged
bleeding after surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy or Radiation therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS or HIV positive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver disease, Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug/Alcohol rehab/Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Unusual reactions to anesthetic or drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No | TMJ problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Neck/Back injury/Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Use alcoholic Beverages? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever smoked? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you wear contact lenses | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how many packs daily _____ | Years _____ |
| Sleep Apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

List allergies to drug/medications (such as penicillin, codeine, etc.): _____

List prescription medications (including birth control pills): _____

List non-prescription medications, diet pills, alcohol or recreational drugs used in the last seven (7) days (Aspirin, Ginko Biloba, St. John's Wort, allergy, cocaine, marijuana); _____

List all previous surgeries/hospitalizations (type and date): _____

Is there any other information about your health which we should know about or that you would like to discuss with the Doctor in private?

MEDICAL INFORMATION CERTIFICATION

I hereby certify that the information listed above which I have provided regarding the medical history and status of _____ is completed, true, and correct and may be relied upon for all purposes by Oral and Maxillofacial Associates, Inc., their assistants, colleagues, staff, and employees, and any other persons treating or assisting in the treatment of the patient.

UPDATE	DOCTOR	PATIENT

Patient (or legally authorized individual) Signature

Signature _____ Relationship: _____ Date: _____

OMA Witness: _____ Date: _____