



THE ORAL SURGERY CENTER

MEDICAL HISTORY FORM

NAME DATE OF BIRTH

For the following questions check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, your responses will be reviewed and additional questions may be asked.

	Yes	No
1. Are you in good health	<input type="checkbox"/>	<input type="checkbox"/>
2. Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>
3. My last physical examination was on	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
5. The name and address of my physician(s) is		
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.....		
6. Have you had any serious illness, operation, or been hospitalized in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you taking any medicine(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what medication(s) are you taking?		
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.....		
8. Do you take any illegal controlled substance/drugs?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you routinely take prophylactic antibiotics prior to dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you smoke or use chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have or have you had any of the following diseases or problems?		
a. Damaged heart valves or artificial valves, including heart murmur or rheumatic heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion)	<input type="checkbox"/>	<input type="checkbox"/>
1. Do you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have chest pain upon exertion?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you ever short of breath after mild exercise or when lying down?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do your ankles swell?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have inborn heart defects?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a cardiac pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you had surgically placed artificial joints or other materials?	<input type="checkbox"/>	<input type="checkbox"/>
d. Allergies or hayfever	<input type="checkbox"/>	<input type="checkbox"/>
e. Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
f. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
g. Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>
h. Persistent diarrhea or recent weight loss	<input type="checkbox"/>	<input type="checkbox"/>
i. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
j. Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>
k. AIDS or any condition which compromises the immune system	<input type="checkbox"/>	<input type="checkbox"/>
l. Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
m. Respiratory problems, emphysema, bronchitis, etc	<input type="checkbox"/>	<input type="checkbox"/>
n. Arthritis or painful swollen joints	<input type="checkbox"/>	<input type="checkbox"/>
o. Stomach ulcer or hyperacidity	<input type="checkbox"/>	<input type="checkbox"/>
p. Kidney trouble	<input type="checkbox"/>	<input type="checkbox"/>
q. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
r. Persistent cough or cough that produces blood	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
s. Persistent swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>
t. Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
u. Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
v. Epilepsy or other neurological disease	<input type="checkbox"/>	<input type="checkbox"/>
w. Problems with mental health	<input type="checkbox"/>	<input type="checkbox"/>
x. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had abnormal bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
a. Have you ever required a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have any blood disorder such as anemia?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had a treatment for a tumor or growth?	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you allergic or have you had a reaction to:		
a. Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
b. Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
c. Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
d. Barbiturates, sedatives or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
e. Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
f. Iodine	<input type="checkbox"/>	<input type="checkbox"/>
g. Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
h. Latex or rubber products	<input type="checkbox"/>	<input type="checkbox"/>
i. Any other medications or products? (Please List)	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you had any serious trouble associated with any previous dental treatment? If so, please explain:		
17. Do you have any disease, condition, or problem not listed above that you think the Doctor should know about? If so, please explain:	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
19. Are you wearing removable dental appliances?	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you have pain in or near your ears or near your jaw joint?	<input type="checkbox"/>	<input type="checkbox"/>
21. Does any part of your mouth hurt when clenched or feel tired upon awakening?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you have chronic headaches, neck or shoulder pain?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you have a clicking jaw joint or other joint noise?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you experienced and growth or sore spots in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you have any loose or sensitive teeth?	<input type="checkbox"/>	<input type="checkbox"/>
26. Do your gums bleed?	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN

27. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
28. Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
29. Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

CHIEF DENTAL COMPLAINT

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I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the doctor, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient Date

(Parent/legal guardian if under age 18)

Date (Staff Initial)