

# NORTHEAST ORAL & MAXILLOFACIAL SURGERY



## Medical History

Patient Name: \_\_\_\_\_  
First
MI
Last
Nickname

Reason for today's office visit: \_\_\_\_\_

	Yes	No	Notes
Are you in good health?			
Height _____   Weight _____   Age _____			
Are you under the care of a physician? If yes, date of last visit _____			
For what were you being treated?			
Have you ever had any illness or been hospitalized?			
If yes, please explain: _____			

Please indicate if you have had any of the following conditions:							
	Yes	No	Notes		Yes	No	Notes
Heart Disease				Radiation Treatment			
Chest Pains				Anemia			
Heart Murmur				Bleeding Problems			
Mitral Valve Prolapse				Stomach Ulcers			
Rheumatic Fever				HIV or AIDS			
High Blood Pressure				Tumors/Growths			
Artificial Heart Valve				Chemotherapy			
Pacemaker				Hepatitis or Jaundice			
Stroke				Diabetes			
Bruising				Thyroid Disease			
Glaucoma				Kidney Disease			
Fainting Spells				Arthritis			
Chronic Fatigue				Artificial Joints			
Asthma				Seizures (Epilepsy)			
Lung Disease				Cancer			
Tuberculosis				Swollen Ankles			
Hay Fever/Sinus				Liver Disease			
Shortness of Breath				Alcohol/Drug Abuse			
Snoring				Delayed Healing			

	Yes	No	Notes
Are you allergic to anything (ie. latex, tape, antibiotics or pain medications)? If yes, please list:			
Are you currently taking any drugs or medications? If yes, please list:			
Have you ever had any adverse reaction to an anesthetic? If yes, please list:			
Have you ever had or been treated for clicking or pain in your jaw joint (TMJ)? If yes, please list:			
Have you ever had any unusual problems with previous dental work? If yes, please list:			
Is this visit a result of an accident? If yes, please list:			
Do you smoke?			
Have you ever taken diet pills (ie. Fen-Phen or Redux)?			
Are you taking any herbal medications (ie. St. John's Wort)?			
Women: Are you taking birth control pills?			
Are you pregnant?			
Are you nursing?			
Do you have any other conditions or problems we should know about prior to treatment? If yes, please list:			
Do you have any history of family diseases that we should know about? If yes, please list:			

I hereby certify that the above information is accurate and complete to the best of my knowledge.

Patient or Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_