SOUTH BEDFORD
ORAL & MAXILLOFACIAL SURGERY

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MEDICAL HISTORY FORM

Today's date: _____ **Patient name:** _____

Patient date of birth: _____ **Name of person completing form:** _____

*****Please circle yes or no to each of the following questions – all questions must be answered*****

1. Are you in good health? ..... Yes / No
2. Have there been any changes to your health in the last year? ..... Yes / No
3. Your last physical examination was on: _____
4. Are you now under the care of a physician? ..... Yes / No

   If so, what condition is being treated? _____

5. Please circle all of the following that apply to you:

Coronary (Heart) Disease	Endocarditis	Stomach Ulcers / Colitis	Thyroid Disease
Stroke / TIA	Circulatory Problems	Diverticulitis / Diverticulosis	Sinus Disease
Rheumatic Fever	Headaches	Acid Reflux / GERD	Tuberculosis
Rheumatic Heart Disease	Prostate Disease	Venereal Disease	Seizures / Epilepsy
Mitral Valve Prolapse	Immune Suppression	Gonorrhea / Herpes / Syphilis	Other Neurological Disorder
Heart Murmur	Persistent Cough / Bloody Cough	Psychiatric Disorders	Dizziness / Fainting Spells
Heart Valve Replacement	Asthma / Emphysema / COPD	Depression	Abnormal Bleeding
Heart Attack	Cancer / Malignancy	Anemia	Chemotherapy / Radiation Therapy
Angioplasty / Pacemaker	Multiple Myeloma	Hives / Skin Rash	
Irregular Heart Beat	Paget's Disease	TMJ (Temporomandibular Disease)	Snoring / Sleep Apnea
Heart Failure	Kidney Disease / Transplant		
Angina / Chest Pains	Liver Disease / Transplant	Hay Fever / Seasonal Allergies	Other:_____
Congenital Heart Defects	Hepatitis or Jaundice	Mononucleosis	
High Blood Pressure	Arthritis	Glaucoma	_____
Low Blood Pressure	Osteoporosis	Hip or other Joint Replacement	_____
	Diabetes		

6. Have you ever had any surgery, hospitalization, or serious illness of any kind? ..... Yes / No
   a. If yes, what and when _____
7. Do you smoke or use other tobacco products? ..... Yes / No
   a. If yes, how much per day? _____
8. Please circle yes if you are allergic or have reacted adversely to any of the following – otherwise, please circle no:

Aspirin	Yes / No	Foods	Yes / No	Codeine or other narcotics	Yes / No
Penicillin	Yes / No	Iodine / X-Ray dye	Yes / No	Local anesthetics (Novocaine)	Yes / No
Sulfa drugs	Yes / No	Latex / Natural rubber	Yes / No	Other (please list) _____	
Egg / egg yolk.....	Yes / No	Sedatives or barbiturates ...	Yes / No	_____	

9. Do you take any medications? ..... Yes / No

Please list all medications, including over-the-counter medications (such as vitamins, aspirin, Motrin or Tylenol):

_____

_____

Patient Name : _____

10. Are you taking or have you ever taken any of the following medications orally or by injection (typically used for osteoporosis or chemotherapy for multiple myeloma, Paget's Disease, prostate cancer or breast cancer; these are either bisphosphonate medications or receptor activator NFκB ligands [RANKL]): Yes / No

- Risedronate (Actonel)
- Alendronate (Fosamax)
- Ibandronate (Boniva)
- Zoledronic Acid (Reclast / Zometa)
- Pamidronate (Aredia)
- Etidronate (Didronel)
- Denosumab (Prolia)

11. Are you, or have you been, in a drug or alcohol recovery program? ..... Yes / No
    a. Do you use alcohol, marijuana, cocaine or other "recreational" drugs? ..... Yes / No
12. Have you ever required a blood transfusion? ..... Yes / No
13. Have you ever been treated for a growth, tumor, or cancer of the head or neck? ..... Yes / No
14. Do you experience any of the following:
    a. Chest pain upon exertion? ..... Yes / No
    b. shortness of breath after mild exercise? ..... Yes / No
    c. swelling of your ankles? ..... Yes / No
    d. excessive thirst or frequent urination? ..... Yes / No
    e. easy bruising or prolonged bleeding after surgery or dental procedures? ..... Yes / No

15. Do you wear any removable dental appliances? ..... Yes / No
16. Have you had any serious problems associated with any previous dental treatment? ..... Yes / No
17. Have you or an immediate family member had any problem associated with intravenous sedation or general anesthesia? Yes / No
18. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Yes / No
19. Do you wish to talk to the doctor privately about anything? ..... Yes / No

20. FOR WOMEN ONLY

    a. Are you pregnant, or is there any chance that you might be pregnant? ..... Yes / No
    b. Are you nursing? ..... Yes / No
    c. Do you have any problems associated with your menstrual period? ..... Yes / No
    d. If you are using oral contraceptives (birth control pills), it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the information I provide on this form is essential to determine my dental needs and the provision of treatment. I understand that if any change occurs in my health I must report it to the office as soon as possible. I have read and understand these questions and answered them all truthfully and to the best of my ability, and I have had an opportunity to discuss my health history with the doctor. Furthermore, I hereby give consent to perform necessary diagnostics tests (including X-Rays) and evaluation of my dental records.

_____

Patient (Guardian) Signature Date