ORAL AND MAXILLOFACIAL
SURGERY OF THE LOWCOUNTRY

Medical History

Please fill out the form as completely as you can. The scope of surgery includes the diagnosis and treatment of disease, injuries, and defects involving the functional and esthetic aspects of the tissues in the oral and maxillofacial regions. Health problems may affect outcome of treatment. Incorrect or withheld information can be dangerous to your health.

Name: ____ **Date:** ____________________

Why have you come to see us today: ____

Are you having any pain? ☐ **Yes** ☐ **No** **If yes, please rate on a scale of 1 to 10:** ______

Are you currently under the care of a physician? ☐ **Yes** ☐ **No** **Age** _____ **Height** ______ **Weight** ______

Your Physician's Name: ______________________ **Phone Number:** ________________**Last seen date:** ________

Please List all Medications and Herbal Supplements/Vitamins you are taking: ______________________________

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1. Do you take **Blood Thinners** (anticoagulants … Coumadin, Plavix, Aspirin, Ginko Biloba) ☐ **Yes** ☐ **No**
2. Have you EVER taken bisphosphonate medications for osteoporosis/osteopenia such as Fosamax, Boniva, Actonel, Reclast? ☐ **Yes** ☐ **No** If yes, which one and for how long? ______________________________

   Have you ever taken bone replacement drugs/chemotherapy used in multiple myeloma and other bone cancers such as Zometa and Aredia? ☐ **Yes** ☐ **No** If yes, which one and for how long? ______________________________
3. Have you EVER taken steroids (i.e. prednisone), diet pills (such as Fen-Fen)? ☐ **Yes** ☐ **No** If yes, when: ______________
4. Are you allergic to any of the following: ☐ **No Known Drug Allergies (NKDA)**

   ☐ Aspirin ☐ Codeine ☐ Codeine Derivative (Hydrocodone/Oxycodone) ☐ Local Anesthetics
   ☐ Erythromycin/Z-pack ☐ Penicillin/Amoxicillin's ☐ Tetracycline ☐ Sulfa Drugs ☐ General Anesthetics
   ☐ Soybeans ☐ Eggs ☐ Latex ☐ Tape Adhesive

   Other allergies: ____
5. Have you ever had surgery or been hospitalized before? ☐ **Yes** ☐ **No**

   List: ____

   ____
6. Have you taken or been told you need antibiotic premedication prior to dental treatment? ☐ **Yes** ☐ **No**
7. Do you smoke or chew tobacco? ☐ **Yes** ☐ **No** If yes, how much per day and for how long: ____________________
8. Did you smoke in the past? ☐ **Yes** ☐ **No** If yes, when did you quit? ____________________
9. Do you drink alcohol? ☐ **Yes** ☐ **No** If yes, how much per day or week? ____________________
10. Do you use recreational drugs? *This is asked for safety with anesthesia* ☐ **Yes** ☐ **No** If yes, list____________________
11. Have you EVER used cocaine? *This is asked for safety with anesthesia* ☐ **Yes** ☐ **No** If yes, when? ________________
12. Have you or family members EVER had trouble with anesthesia? ☐ **Yes** ☐ **No** If yes, please describe:

    ____

13. Please check box if you had or are now having any of the following:

☐ **High blood pressure** ☐ **Chest pain** ☐ **Prosthetic heart valves** ☐ **Stroke**
☐ **Atrial Fibrillation (A-Fib)** ☐ **Heart murmur** ☐ **Rheumatic fever**
☐ **Mitral valve prolapse** ☐ **Pacemaker** ☐ **Irregular heart beat**
☐ **Heart attack** ☐ **Heart Catheterization** ☐ **Heart Surgery** ☐ **Transfusion**

☐ **COPD** ☐ **Asthma** ☐ **Bronchitis** ☐ **Seasonal Allergies**
☐ **Chronic cough** ☐ **Emphysema** ☐**Shortness of Breath** ☐ **Sinus Infections**
☐ **Sleep Apnea** ☐ **Tuberculosis**

☐ **Anemia** ☐ **Hemophilia** ☐ **Blood disease** ☐ **Excessive bleeding**
☐ **Hepatitis** ☐ **HIV** ☐ **Herpes** ☐ **STD**
☐ **Headaches** ☐ **Fainting** ☐ **Kidney disease** ☐ **Dialysis**
☐ **Liver disease** ☐ **Thyroid disease** ☐ **Diabetes:** ☐ **Type I** or ☐ **Type II**

☐ **Cancer** ☐ **Radiation** ☐ **Chemotherapy**

☐ **Arthritis** ☐ **Neck/Back problems** ☐ **Grinding or clenching of teeth** ☐ **Pain/popping/clicking of the jaw joint**
☐ **History of TMJ treatment** ☐ **Any previous bad experiences or problems with dental treatment**

☐ **Artificial joints (i.e. Hip/Knee) - Date of surgery** ______________________

☐ **Epilepsy** ☐ **Seizure** ☐ **Glaucoma** ☐ **Deafness**
☐ **Anxiety** ☐ **Psychiatric treatment**
☐ **Stress** ☐ **Skin rash** ☐ **Malignant hyperthermia**

14. Do you have any other conditions not listed above? ____
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15. Is there anything you would like to discuss in private with the doctor? ☐ **Yes** ☐ **No**

For Female Patients Only

1. Are you pregnant, or is there any chance you might be pregnant? ☐ **Yes** ☐ **No**
   If yes, how far along are you? __________
2. Please provide the approximate date of your last menstrual period: ______________________
3. Are you nursing? ☐ **Yes** ☐ **No**

If you are using oral contraceptives, it is important that you understand that antibiotics 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 importance of a truthful and complete health history to assist the doctor in providing the best possible care. I have read and understand the above information.

____
Print **Patient/Guardian Signature** **Date**

For Office Use Only: ______________________ __________ __________ __________
Reviewer Date Doctor Initial Date

Medical Update: __________ ______________________ ______________________ __________
Date Changes Patient/Guardian Signature Date