LAKEVIEW
ORAL MAXILLOFACIAL SURGERY & MED SPA

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DOWNTOWN
ORAL MAXILLOFACIAL SURGERY

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PATIENT MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No
If so, for what are you being treated? _____

Have you had any illness, operation or been hospitalized in the past five years? ○ Yes ○ No
If so, what is the reason? _____

Are you allergic to, or had reaction to the following?

○Yes ○No Aspirin ○Yes ○No Codeine ○Yes ○No Latex ○Yes ○No Sulfa ○Yes ○No Amoxicillin
○Yes ○No Versed / Valium / Other tranq. ○Yes ○No Penicillin ○Yes ○No Local anesthesia (numbing med)
○Yes ○No Other _____

WOMEN (Please check) ○Yes ○No Pregnant ○Yes ○No Trying to get pregnant ○Yes ○No Nursing
○Yes ○No Taking oral contraceptive

Do you have or have ever had any of the following? Please check yes or no:

Abnormal Bleeding	○Yes	○No	Chemotherapy	○ Yes	○No	Heart Attacks	○ Yes	○No
Anemia	○Yes	○No	Chest Pain	○ Yes	○No	Hepatitis	○Yes	○No
Angina	○Yes	○No	Chronic Cough/Pneumonia	○ Yes	○No	High/ Low Blood Pressure	○ Yes	○No
Arthritis	○Yes	○No	Diabetes	○ Yes	○No	HIV/AIDS	○ Yes	○No
Artificial Joints	○Yes	○No	Difficult Breathing	○ Yes	○No	Kidney Disease	○ Yes	○No
Artificial Heart Valves	○Yes	○No	Epilepsy or Seizures	○ Yes	○No	Lung Trouble	○ Yes	○No
Asthma	○Yes	○No	Emphysema	○ Yes	○No	Osteoporosis / Osteopenia	○ Yes	○No
Bleeding Tendency	○Yes	○No	Fainting or Dizziness	○ Yes	○No	Rheumatic Fever	○ Yes	○No
Blood Transfusion	○Yes	○No	Frequent Cold or Cough	○ Yes	○No	Sinus Problems	○ Yes	○No
Breathing Problems	○Yes	○No	Hay Fever	○ Yes	○No	Smoke	○ Yes	○No
Bronchitis	○Yes	○No	Heart Murmur	○ Yes	○No	Stroke	○ Yes	○No
Bruise Easily	○Yes	○No	Heart Pace Maker	○ Yes	○No	Stomach Ulcers	○ Yes	○No
Cancer	○Yes	○No	Heart Surgery	○ Yes	○No	Tuberculosis	○ Yes	○No
						Ulcerative Colitis	○ Yes	○No

Are you taking, or have you ever taken, any of the following medications for any type of cancer, osteoporosis or bone loss due to aging, Paget's Disease, or multiple myeloma?..... ○ Yes ○ No

If yes, please check the appropriate medication below:

Nitrogen Containing Bisphosphonates – IV ○ Other _____

○Yes ○No Pamidronate (Aredia, Rhoxal) ○Yes ○No Neridonate
○Yes ○No Clodronate (Bonefos) ○Yes ○No Zoledronate (Zometa, Aclasta, Reclast)

Nitrogen Containing Bisphosphonates – Oral ○ Other _____

○Yes ○No Alendronate (Fosamax, Fosamax+D, Fosavance) ○Yes ○No Olpadronate
○Yes ○No Ibandrone (Boniva, Bondronat) ○Yes ○No Risedronate (Actonel, Atelvia)

To the best of my knowledge, all of the proceeding answers are correct. If I have any changes in my health status or if any medications changes, I will inform the dentist and staff at the next appointment without fail.

X _____ Date _____
Signature of patient, parent or guardian