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 effect outcome of treatment. Incorrect or withheld information can be dangerous to your health. If you have any questions, we would be glad to help you. Your information is for our office only and will be kept confidential.

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 you are taking: _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

1. Do you take **Blood Thinners** (anticoagulants … Coumadin, Plavix, Aspirin, Ginko Biloba) ☐ **Yes** ☐ **No**
2. Have you EVER taken bisphonate 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), herbal supplements, diet pills (such as Fen-Fen) or vitamins? ☐ **Yes** ☐ **No**
   If yes, please list: _____
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:

    _____

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

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

☐ **Respiratory disease** ☐ **Asthma** ☐ **Bronchitis** ☐ **Malignant hyperthermia**
☐ **Chronic cough** ☐ **Emphysema** ☐ **Hay fever** ☐ **Sinus trouble**
☐ **Sleep Apnea** ☐ **Tuberculosis**

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

☐ **Cancer** ☐ **Radiation** ☐ **Chemotherapy** ☐ **Resective cancer surgery**

☐ **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** ☐ **Stroke**

14. Do you have any other conditions not listed above?_____
_____

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.

_____
Patient/Guardian Signature Date

Print Name: _____

For Office Use Only: _____ _____ _____ _____
Reviewer Date Doctor Initial Date

Addendum

Medical Update: _____ _____ _____ _____
Date Changes Patient/Guardian Signature Date