Oral & Facial Surgery Center

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HEALTH HISTORY

For Office Use Only - Do Not Write in This Space

Patient ___________________________ Referral _____________________________ Date __________

BP _______________ Pulse _______________ Resp ______________ Age _________ Wt ___________

C.C.-

Allergies ______Meds______ ______Medical Problem List______

1) Have you been hospitalized or had any serious illness in the past five years? Yes _______ No _______
If Yes, explain: ____.

2) The Name of your medical doctor is ____.

3) Please circle any of the following conditions which you have had:

Heart Trouble	Diabetes	Cancer
Damaged Heart Valve/ Mitral Valve Prolapse	Glaucoma	Radiation Treatment
	Anemia	Venereal Disease
Heart Murmur	Asthma	HIV/AIDS
Chest Pain	Emphysema	Alcohol/Drug Abuse
Heart Attack	Tuberculosis	Anesthesia Problems
Pacemaker	Stroke	Stomach Ulcers
High Blood Pressure	Seizures	Hepatitis
Kidney Problems/Dialysis	Fainting Spells	Arthritis

4) Do you smoke? Yes ___ No ___

5) If there are any medical problems not listed that you think we should know, please explain: ____
____.

WOMEN ONLY:

6) Is there any chance that you are pregnant? Yes ___ No ___ Not Sure ___

7) Any elective surgery and anesthesia during pregnancy is potentially harmful to the developing fetus. You have the option of consulting with your physician to rule out pregnancy before your surgical procedure. Do you wish to consult with your physician about the possibility of pregnancy prior to scheduling your surgery?
Yes ___ No ____

X______________________________________
Signature of Patient (or parent if patient is a minor)

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