ORAL & MAXILLOFACIAL
SURGERY
OF OCEAN PARKWAY

Chart Number: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

What is the reason for today's visit? _____

I. CIRCLE APPROPRIATE ANSWER:

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? _____
4. Yes No Are you being treated by a physician now?
   For what? _____
   _____
   Date of last medical exam: _____
   Date of last Dental exam: _____
5. Yes No Have you had problems with prior dental treatment?
6. **Yes No Allergies to: drugs, foods, medications, latex?**
7. **Yes No Are you taking blood thinners?**

II. HAVE YOU EXPERIENCED:

8. Yes No Chest pain (angina)?
9. Yes No Swollen ankles?
10. Yes No Shortness of breath?
11. Yes No Recent weight loss, fever, night sweats?
12. Yes No Persistent cough, coughing up blood?
13. Yes No Bleeding problems, bruising easily?
14. Yes No Sinus problems?
15. Yes No Difficulty swallowing?
16. Yes No Diarrhea, constipation, blood in stools?
17. Yes No Frequent vomiting, nausea?
18. Yes No Difficulty urinating, blood in urine?
19. Yes No Dizziness?
20. Yes No Ringing in ears?
21. Yes No Headaches?
22. Yes No Fainting spells?
23. Yes No Blurred vision?
24. Yes No Seizures?
25. Yes No Excessive thirst?
26. Yes No Frequent urination?
27. Yes No Dry mouth?
28. Yes No Jaundice?
29. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

30. Yes No Heart disease?
31. Yes No Heart attack, heart defects?
32. Yes No Heart murmurs?
33. Yes No Prosthetic heart valve, internal defibrillator, pace maker?
34. Yes No Rheumatic fever?
35. Yes No Stroke, hardening of arteries?
36. Yes No High blood pressure?
37. Yes No Asthma, TB, emphysema, other lung diseases?
38. Yes No Sleep Apnea?
39. Yes No Hepatitis, other liver disease?
40. Yes No Stomach problems, ulcers?
41. Yes No Family history of diabetes, heart problems, tumors?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin diseases?
45. Yes No HIV+/AIDS, VD (syphilis or gonorrhea)?
46. Yes No Herpes?
47. Yes No Kidney, bladder disease?
48. Yes No Thyroid, adrenal disease?
49. Yes No Diabetes?
50. Yes No Psychiatric care?
51. Yes No Radiation treatments, tumors, cancer?
52. Yes No Chemotherapy?
53. Yes No Artificial joint? Example: hip or knee replacement
54. Yes No Hospitalizations?
55. Yes No Anemia?
56. Yes No Blood transfusions?
57. Yes No Surgeries?

IV. ARE YOU TAKING:

58. Yes No Recreational drugs?
59. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
    Please list: _____
    _____
    _____
    _____
60. Yes No Tobacco in any form?
61. Yes No Alcohol?

V. WOMEN ONLY:

62. Yes No Are you pregnant?
63. Yes No Are you nursing?
64. Yes No Taking birth control pills?

VI. ALL PATIENTS:

65. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
    If so, please explain: _____
    _____
    _____
    _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications.

Patient's signature: **X** _____ Date: _____

Doctor's signature: _____ Date: _____