CLARK HOLMES

ORAL FACIAL SURGERY

PAST MEDICAL HISTORY

Patient's Name _____

Physician's Name _____ Care of Physician? _____

Allergies _____ Serious illness? _____

Current medications and dose (include vitamins and herbal medications) _____ Cancer, tumor, malignancy? (type) _____

_____ _____

AIDS / HIV exposure? Positive? _____

History of diet pills? _____ Hospital admissions? _____

Alcohol & tobacco use (type & amount) _____ Operations? (Where, when, what?) _____

Pregnant or nursing? (past & present) _____ _____

Illicit drug use? _____ Transfusions? When? _____

REVIEW OF SYSTEMS

General	Yes	No	Comment
Fevers	○	○	
Night sweats	○	○	
Weakness	○	○	
Weight gain / loss	○	○	
Eyes			
Last eye exam	○	○	
Corrective lenses	○	○	
Tearing	○	○	
Seeing spots	○	○	
Contact lenses	○	○	
Ear, Nose, Throat, Mouth			
Hearing test	○	○	
Dizziness	○	○	
Vertigo	○	○	
Nose bleeds	○	○	
Nasal discharge	○	○	
Sore throat	○	○	
Mouth lesions	○	○	
Gastrointestinal			
Ulcers	○	○	
Hepatitis	○	○	
Cirrhosis	○	○	
Endocrine			
Diabetes	○	○	
Adrenal disorders	○	○	
Thyroid disorders	○	○	
Steroids	○	○	

Respiratory	Yes	No	Comment
Tuberculosis	○	○	
Asthma	○	○	
Shortness of breath	○	○	
Emphysema	○	○	
Neurologic			
Stroke	○	○	
Seizures	○	○	
Psychiatric	○	○	
Fainting	○	○	
Paralysis	○	○	
Cardiovascular			
Chest pain	○	○	
Heart attack	○	○	
Heart murmur	○	○	
Edema	○	○	
High blood pressure	○	○	
Congenital heart defect	○	○	
Hematologic			
Anemia	○	○	
Bleeding disorders	○	○	
Anticoagulants	○	○	
Leukemia	○	○	
Low blood count	○	○	
Family History			
Heart trouble	○	○	
Diabetes	○	○	
Anesthesia problems	○	○	
Cancer (type)	○	○	

For patients having general anesthetic or sedation:

Have you had anything to eat or drink in the last 6 hours? Yes No Do you have someone to drive you home? Yes No

* Patients having General Anesthesia or sedation must have a responsible person to stay *in the building* during the procedure, available to *sit in recovery* after surgery and *to drive* you home.

Reviewed _____ Date _____