**SCHAUMBURG ORAL & MAXILLOFACIAL SURGERY MEDICAL HISTORY FORM**

Name:_____ Date:_____

Date of Birth: _____ Sex: M___ F___ Height:_____Weight: _____

Physician Name & Phone:_____ Date of Last Physical Exam:_____

Specialist Name & Phone:_____ Other: _____

**Please complete the Health History so that we may provide the best possible care; the doctor will discuss the History with you prior to beginning treatment.**

**I. DO YOU HAVE OR HAVE YOU EVER HAD:**

**Y___ N___ Cardiovascular disease?(Heart attack,coronary artery disease,angina,chest pain,irregular heart rate or palpitations, congenital heart disease,rheumatic heart disease,heart murmur) Please explain: _____**
**_____**

**Y___ N___ Heart Surgery? (Bypass,stent,pacemaker,defribrillator)**
**Y___ N___ High or Low Blood Pressure**
**Y___ N___ Stroke**
**Y___ N___ Respiratory disease? (asthma,emphysema, COPD, bronchitis, Tuberculosis)**

**Y___ N___ HIV/AIDS?**
**Y___ N___ Do you bruise or bleed easily?**
**Y___ N___ Blood transfusion?**
**Y___ N___ Blood Disorder? (Clotting, Hemophilia, Anemia)**

**Y___ N___ Liver disease? (Jaundice,Hepatitis-A-B-C)**
**Y___ N___ Kidney Disease?**
**Y___ N___ Thyroid Disease?**
**Y___ N___ Organ Transplant?_____**

**Y___ N___ Snoring or Sleep Apnea?**
**Y___ N___ Sinus or nasal problems?**
**Y___ N___ Seasonal allergies? Hay Fever?**

**Y___ N___ Arthritis?**
**Y___ N___ Osteoporosis?**
**Y___ N___ Implants or Joint Replacements?_____**
**Y___ N___ Any GI disease? (stomach ulcers,acid reflux,GERD)**

**Y___ N___ Cancer? _____**
**Y___ N___ Chemotherapy?**
**Y___ N___ Radiation therapy?**
**Y___ N___ Venereal Disease?**
**Y___ N___ Porphyria?**

**Y___ N___ Disease or medication that depress immunity?**
**Y___ N___ Diabetes? Type I___ or Type II___**
**Y___ N___ Glaucoma?**
**Y___ N___ Psychiatric/Nervous disorders?**

**Y___ N___ Speech/Hearing Disorders?**
**Y___ N___ Epilepsy or seizures?**
**Y___ N___ Fainting? Dizziness? Motion Sickness?**

**II. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO ANY OF THE FOLLOWING:**

**Y___ N___ Local Anesthesia (Novocain,etc)**
**Y___ N___ Any antibiotics? _____**
**Y___ N___ Sedatives, barbiturates**
**Y___ N___ Aspirin or Ibuprofen**
**Y___ N___ Other allergies or reactions: _____ _____**
**_____ _____ _____**

**Y___ N___ Chemicals or Jewelry (rash or sensitivity)**
**Y___ N___ Food products? Soy? Eggs? Peanuts?**
**Y___ N___ Latex or rubber products**
**Y___ N___ Codeine or other pain medication**

**III. ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING:**

**Y___ N___ Antibiotics _____**
**Y___ N___ Anticoagulants or blood thinners (Coumadin,Plavix,etc) _____**
**Y___ N___ Aspirin or Ibuprofen _____**
**Y___ N___ Steroids (cortisone,prednisone,etc) _____**
**Y___ N___ Insulin or oral anti-diabetic drugs _____**
**Y___ N___ Allergy Medications: (Zirtec,Allegra,Claritin)**

**PLEASE ATTACH OR LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:**

_____ _____
_____ _____
_____ _____

**IV. HAVE YOU EVER TAKEN:**

**Y___ N___ Diet Pills**
**Y___ N___ Bisphosphonate bone density medication (Reclast,Fosamax,Actonel,Boniva,Aredia,Zometa)**
**Y___ N___ Tranquilizers, sleep aids, antidepressants, narcotics**
**Y___ N___ Have you ever been advised to NOT Take a medication? _____**

**V. GENERAL INFORMATION:**

**Are you in good health? _____Yes _____No**
**Are you now under a physician's care for a particular problem? If so, describe: _____**

**_____**

**Has there been any change in your general health in the past year? If so, describe: _____**

**_____**

**Have you ever had any serious illness? If so, describe: _____**

**_____**

**Have you been hospitalized or had surgery during the last 5 years? If so, describe: _____**

**_____**

**Y___ N___ Do you smoke or chew tobacco? How much? _____ For how long? _____**

**Y___ N___ Do you have a current or past history of alcohol or chemical dependency?**

**Explain: _____**

**Y___ N___ Have you had any serious problems associated with previous dental treatment?**

**Explain: _____**

**Y___ N___ Do you have pain, clicking or popping of the jaw joint or difficulty opening your mouth?**

**Y___ N___ Do you grind or clench your teeth?**

**Y___ N___ Have you or an immediate family member ever had any problem with general anesthesia?**

**Explain: _____**

**Please list any other disease, condition or problem not listed above that you think the doctor should know about. _____**

**Explain: _____**

**VI. FOR FEMALE PATIENTS ONLY:**

**Y___ N___ Are you pregnant or is there any chance you might be pregnant? If so, when is your due date? _____**
**Y___ N___ Are you nursing?**
**Y___ N___ Are you currently taking Birth Control Pills? If so, it is important that you understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. You may need to use an additional form of birth control for one cycle of birth control pills after a course of antibiotics or other medication is completed. Please consult with your physician.**

**Y___ N___ Do you wish to talk to the doctor privately about anything?**

**The above answers are correct and true to the best of my knowledge at this time. I understand the importance of a truthful and complete health history to assist the doctor in providing the best possible care.**

**Patient/Legal Guardian: _____ Date: _____**

**Doctor: _____ Date: _____**