

# Dr. Max Moncayo Oral Surgeon

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: Male / Female

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.**

Please describe your current health:      Excellent      Good      Fair      Poor

Please describe the symptoms you are currently having today: \_\_\_\_\_

Have there been any changes in your general health in the past year?      Yes      No

If yes, please describe: \_\_\_\_\_

Are you now under a physician's care for a particular problem at this time?      Yes      No

If yes, why? \_\_\_\_\_ Date of last physical exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever been hospitalized or had a serious illness?      Yes      No

If yes, why? \_\_\_\_\_

## PATIENT MEDICAL HISTORY

### Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
			Glaucoma?	Yes	No

Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
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Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
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Thyroid disease?	Yes	No	Diabetes?	Yes	No
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Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
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Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No

Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
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Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No
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Any disease, chemotherapy or transplant operation? Cancer?				Yes	No
If so, where? _____, and when was the date of your last treatment? _____					

Do you have any other disease, condition or problem not listed above that you think the doctor should know about?      Yes      No

If yes, please explain: \_\_\_\_\_

## FAMILY MEDICAL HISTORY

### Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes?	Yes	No	Relationship _____	Cancer?	Yes	No	Relationship _____
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Heart disease?	Yes	No	Relationship _____	Bleeding problems?	Yes	No	Relationship _____
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Tumors?	Yes	No	Relationship _____	Lung disease?	Yes	No	Relationship _____
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## FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant?      Yes      No

# Health History Form

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

## MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Heart drugs?	Yes	No	High blood pressure medications?	Yes	No
Steroids (cortisone, prednisone, etc.)? antianxiety agents, sedative-hypnotics and antidepressants	Yes	No	Bisphosphonates, antiangiogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use.	Yes	No
Prescription pain medication?	Yes	No	_____		

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: \_\_\_\_\_

## ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? \_\_\_\_\_ Relationship? \_\_\_\_\_

Other drug allergies not listed above: \_\_\_\_\_

## SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? \_\_\_\_\_

Have you ever sought professional care or been hospitalized for:

Drug abuse?	Yes	No	Alcohol?	Yes	No	How often?	_____
Emotional disorders?	Yes	No	Marijuana?	Yes	No	How often?	_____
Alcoholism?	Yes	No	Recreational drugs?	Yes	No	How often?	_____

## DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? \_\_\_\_\_

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.  
To the best of my knowledge, the above information is complete and correct.

\_\_\_\_\_  
Signature of patient, parent, guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient, parent, guardian/Relationship

\_\_\_\_\_  
Doctor's Signature

## HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature
_____	_____	_____
_____	_____	_____