# ORAL and MAXILLOFACIAL ASSOCIATES
## Patient Medical History

Name:_____Weight:_____Height:_____Age:_____Date of Birth:_____

Name of Physician:_____Ph:_____Name of Dentist:_____Ph:_____

Name of person who referred your to our office:_____Ph:_____Are you under a physicians care? ☐Yes ☐No

If so why?:_____Date of last physical exam_____Are there any limitations to your activities? ☐ Yes ☐ No

### HAVE YOU EVER HAD ANY OF THE FOLLOWING

| | | | |
|---|---|---|---|
| High Blood Pressure | ❑ Yes ❑ No | Joint Replacement | ❑ Yes ❑ No |
| Heart Attack, disease or murmur | ❑ Yes ❑ No | Steroids within the last year | ❑ Yes ❑ No |
| Abnormal EKG | ❑ Yes ❑ No | Epilepsy or Seizures | ❑ Yes ❑ No |
| Heart Valve replacement | ❑ Yes ❑ No | Emotional or Psychiatric problems | ❑ Yes ❑ No |
| Rheumatic Fever | ❑ Yes ❑ No | Treatment or counseling | ❑ Yes ❑ No |
| Pacemaker/Defibulator Implant | ❑ Yes ❑ No | Peptic Ulcer or stomach disease | ❑ Yes ❑ No |
| Angina or chest pains | ❑ Yes ❑ No | Kidney disease | ❑ Yes ❑ No |
| Stroke | ❑ Yes ❑ No | Glaucoma | ❑ Yes ❑ No |
| Asthma | ❑ Yes ❑ No | Porphyria (blood disease) | ❑ Yes ❑ No |
| Emphysema or other lung disease | ❑ Yes ❑ No | Complications with tooth extraction | ❑ Yes ❑ No |
| Anemia, Sickle Cell trait/disease | ❑ Yes ❑ No | Are you pregnant or nursing | ❑ Yes ❑ No |
| Blood Transfusions | ❑ Yes ❑ No | Cancer | ❑ Yes ❑ No |
| Bleeding tendency or prolonged bleeding after surgery | ❑ Yes ❑ No | Chemotherapy or Radiation therapy | ❑ Yes ❑ No |
| | | AIDS or HIV positive | ❑ Yes ❑ No |
| Diabetes | ❑ Yes ❑ No | Drug/Alcohol rehab/Therapy | ❑ Yes ❑ No |
| Liver disease, Hepatitis | ❑ Yes ❑ No | TMJ problems | ❑ Yes ❑ No |
| Unusual reactions to an anesthetic or drugs | ❑ Yes ❑ No | Use alcoholic Beverages? | ❑ Yes ❑ No |
| Neck/Back injury/Problems | ❑ Yes ❑ No | Have you ever smoked? | ❑ Yes ❑ No |
| Thyroid Disease | ❑ Yes ❑ No | If yes, how many packs Daily_____Years_____ | |
| Do you wear contact lenses | ❑ Yes ❑ No | Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, for osteoporosis, chemotherapy for multiple myeloma, etc.) | ❑ Yes ❑ No |
| Sleep Apnea | ❑ Yes ❑ No | | |

List allergies to drug/medications (such as penicillin, codeine, etc.);_____

_____

List prescription medications (including birth control pills);_____

_____

List non-prescription medications, diet pills, alcohol or recreational drugs used in the last seven (7) days (Aspirin, Ginkgo Biloba, St. John's Wort, allergy, cocaine, marijuana);_____

List all previous surgeries/hospitalizations (type and date):_____

_____

Is there any other information about your health which we should know about or that you would like to discuss with the Doctor in private?

_____

**MEDICAL INFORMATION CERTIFICATION**

I hereby certify that the information listed above which I have provided regarding the medical history and status of _____ is completed, true, and correct and may be relied upon for all purposes by Oral and Maxillofacial Associates, Inc., their assistants, colleagues, staff, and employees, and any other persons treating or assisting in the treatment of the patient.

| UPDATE | DOCTOR | PATIENT |
|---|---|---|
| | | |
| | | |
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Patient (or legally authorized individual) Signature

Signature_____Relationship:_____Date:_____

OMA Witness:_____Date:_____