

Name: _____ Weight: _____ Height: _____ Age: _____ Date of Birth: _____

Yes No
 Are you presently under a physician's care? If yes, please explain: _____

Physician: _____ Dentist: _____ Orthodontist: _____

ALLERGIES

Yes No	<input type="radio"/> <input type="radio"/> Local anesthetics	Yes No	<input type="radio"/> <input type="radio"/> Codeine/narcotics
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> General anesthetics	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Penicillin(s)
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Aspirin	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Sulfa Drugs
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Others (please list) _____		

MEDICATIONS

Please list any and all medications that you are presently taking (such as antibiotics, pain medication, heart medicine, anti-coagulates, etc.):

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Yes No	<input type="radio"/> <input type="radio"/> High blood pressure	Yes No	<input type="radio"/> <input type="radio"/> Tumor or growth
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Chest pain or angina	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Chemotherapy or radiation therapy
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Heart attack, heart disease	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Seizures, epilepsy
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Damaged heart valve(s), murmur, or mitral valve prolapse (MVP)	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Mental health problems
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Shortness of breath	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Alcohol or drug abuse
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Cardiac pacemaker	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Arthritis
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Stroke	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Jaw joint problems (TMJ)
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Sinusitis, seasonal allergy	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Osteoporosis
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Asthma	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Diabetes
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Emphysema	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Thyroid problems
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Tuberculosis	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Anemia
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Do you smoke? Packs per day: _____	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Sickle cell trait/disease
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Smokeless tobacco? Number of years: _____	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Bruise easily
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Stomach ulcers	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Abnormal or prolonged bleeding
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Kidney problems	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Liver disease hepatitis
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> HIV positive, ARC, AIDS		
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Do you have any breathing problems? _____		
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Do you snore or have you been told that you do? Explain: _____		
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> Do you have any skin problems that you would like us to address, such as acne, fine lines, skin discoloration etc.		

Do you have any cosmetic concerns such as your chin, nose, eyes, etc? _____

Do you have any problems chewing or eating? _____

Have you ever or are you interested in a skin peel? _____

Anything else we should know? _____

FEMALE PATIENTS

<input type="radio"/> <input type="radio"/> Hormone replacement therapy	<input type="radio"/> <input type="radio"/> Birth control pills
<input type="radio"/> <input type="radio"/> Pregnant? Due date: _____	<input type="radio"/> <input type="radio"/> Nursing
<input type="radio"/> <input type="radio"/> Is there any other information about your health that you would like to discuss with your doctor in <i>private</i> ?	

HEALTH INFORMATION CERTIFICATION

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

Signature: _____ Date: _____ Relationship (if other than patient): _____

Signature of doctor/staff: _____ Date: _____

Updated on: _____ Reviewed by: _____ Patient initials: _____

(label)