

Oral Surgery Specialists of Northern Michigan

MEDICAL HISTORY FORM

Patient's Name: _____ Today's Date: _____

Preferred Name/Nickname: _____ Age: _____ Ht: _____ Wt: _____

Reason for the visit today: _____

Have you been under the care of a physician in the past five years? Yes No

If Yes, list reason: _____

Are you taking any drugs or medications (include birth control and any recreational drugs)? Yes No

If Yes, please list: _____

Do you have any food or drug allergies or sensitivities? Yes No

If Yes, please list: _____

Have you had any serious illness, hospitalizations or operations? Yes No

If Yes, please list: _____

Have you received a General Anesthetic (been asleep for surgery)? Yes No

If Yes, any complications: _____

Any family history of complications with General Anesthesia? Yes No

If Yes, explain: _____

Do you smoke? Yes No If Yes: How much? _____ How long? _____ Cough? _____

Women: Are you Pregnant? Yes No Not Certain If Yes: How many months? _____

HAVE YOU EVER HAD OR BEEN TOLD YOU HAVE ANY OF THE FOLLOWING? (indicate)

- 01 Heart Problems
02 Heart Attacks
03 Chest Pains
04 Heart Murmurs
05 Rheumatic Fever
06 High blood Pressure
07 Low Blood Pressure
08 Diabetes
09 Low Blood Sugar
10 Strokes
11 Fainting Spells
12 Glaucoma
13 Contact Lenses
14 Lung Problems
15 Asthma
16 Emphysema
17 Tuberculosis
18 Liver Problems
19 Hepatitis/Jaundice
20 Kidney Problems
21 Stomach Ulcers
22 Arthritis
23 Cortisone/Steroids
24 Blood Disorders
25 Excessive Bleeding
26 Anemia
27 H.I.V. or A.I.D.S.
28 Sexually Transmitted Diseases
29 Epilepsy
30 Seizures or Convulsions
31 Cancer
32 Chemotherapy
33 Radiation Treatments
34 Drug or Alcohol Dependency
35 Prosthetic joints or heart valves
36 Antibiotics before Dental Work

Is there anything else in your health history we should be aware of? Yes No If Yes, please indicate: _____

ACKNOWLEDGEMENT: The information given on this form is truthful and correct to the best of my knowledge.

Date: _____ Signature: _____ Relationship if Minor: _____

FOR OFFICE USE: _____

Reviewed by: _____