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: ______________________________

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

If Yes, please list: ______________________________

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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? ____________

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

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

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

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

Date: __________ Signature: ______________________________ Relationship if Minor: ____________

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FOR OFFICE USE: ______________________________

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Reviewed by: ______________________________