MAINE COAST
ORAL SURGERY

Personal Medical History

Today's Date: ____________________

Patient Name: ____ Date of Birth: ____________________

Name of Physician: ____________________________ Pharmacy: ___________________________________

Dentist: _____________________________________ Orthodontist: _________________________________

Please circle yes or no to the following questions. Your answers are for our records only and are confidential.

1. Yes No Do you consider yourself to be in good health?
2. Yes No Has there been any change in your health in the last year?
3. Yes No Do you have any medical condition that requires physician monitoring? If yes, please describe.

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4. Date of last physical exam: ____

5. Do **you have or have you had** any of the following: If yes, please provide a brief explanation:

Yes No Damaged heart valves, artificial valves
Yes No Rheumatic Heart Disease, Heart Murmur, Mitral Valve Prolapse
Yes No Heart Condition, Heart Attack, Arteriosclerosis
Yes No Chest Pain
Yes No Sinus Trouble
Yes No Shortness of Breath
Yes No Asthma or Hay Fever
Yes No Respiratory Distress, Emphysema, Bronchitis
Yes No Persistent Cough
Yes No Fainting or Seizures
Yes No Epilepsy
Yes No Diabetes
Yes No Hepatitis, Jaundice or Liver Disease
Yes No Frequent or Recurring Mouth Sores
Yes No Thyroid Disorders Hyper ______ Hypo ______
Yes No Arthritis, Painful or Swollen Joints
Yes No Persistent Swollen Neck Glands
Yes No Stomach Ulcer or Hyperacidity
Yes No Kidney Disorders
Yes No Tuberculosis
Yes No High/Low Blood Pressure
Yes No Abnormal Bleeding/Blood Disorder/Blood Transfusion
Yes No Anemia
Yes No Immunity Disorders
Yes No Mental Health Issues
Yes No Cancer/Tumors or Growths

(OVER)

6. Are you allergic to or have you had a reaction to: If yes, please explain what your reaction was:

Yes	No	Local Anesthetic
Yes	No	Penicillin/ Antibiotics
Yes	No	Sulfa Drugs
Yes	No	Barbiturates or Sleeping Pills
Yes	No	Aspirin
Yes	No	Iodine/Seafood
Yes	No	Codeine or Other Narcotics
Yes	No	Other _______________

Height: _________ Weight: _________

7. Are you wearing contact lenses? ____________

8. Have you had any serious trouble associated with previous dental treatment? ______________________________

If so, please describe ____

9. Do you have any other condition or disease we need to be aware of? _____________________________________

If so, please explain ____

10. Have you had a knee, hip, or joint replacement in the last year? _________ Do you have an artificial heart valve? _____________________________ If so, you must pre-medicate with antibiotics prior to oral surgery.

11. Have you had any hospitalizations or surgeries? _________ If so, please list them with approximate dates:

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12. Please list all medications you are taking and the reason for taking them: _________________________________

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13. Chief Dental Complaint (why you are here): ____

14. Do you smoke or use tobacco products? ________ If yes, how much? ___________________________________

15. Do you have a history of substance abuse? _______ If yes, please explain.______________________________

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WOMEN ONLY:

Yes	No	Are you pregnant?
Yes	No	Are you nursing?
Yes	No	Are you taking birth control pills?

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my oral surgeon or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

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Signature of Patient (if patient is a minor, signature of responsible parent or guardian) Date