Woodlands
Oral & Maxillofacial Surgery, P.C.
1635 South Plaza Way
Flagstaff, Arizona 86001
928.214.7052

MEDICAL HISTORY FORM

A complete medical history allows us to provide appropriate care for you.
Please take the time to accurately complete this form.
If needed, bring medical records and your medications with you.

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)
ALL RESPONSES ARE KEPT CONFIDENTIAL

NAME: _____ Date _____
Please Print

SEX: M F BIRTHDATE: _____ AGE: ____

Please list all medications, supplements, remedies and elixirs:

Y N Are you in good health?
Y N Has there been any change in your health since last year?
Y N Have you been treated for any medical condition in the past year?

Who is your Dentist? _____

Y N Are you now under a Physician's care for a particular problem?

Y N Have you had any serious illnesses or operations? If so, describe:

Y N Have you ever been hospitalized? If so, describe:

Y N Have you ever had adverse effects from dental or medical treatment?

Who is your Physician? _____

DO YOU, OR HAVE YOU EVER HAD:

Y N Diabetes: What was your blood sugar today? _____ Time _____
Y N Rheumatic fever or rheumatic heart disease
Y N Congenital heart disease
Y N Heart trouble, heart attack, heart murmur, angina, chest pain
Y N Heart surgery, bypass, pacemaker, defibrillator
Y N High blood pressure
Y N Lung disease, asthma, bronchitis, pneumonia, bronchiectasis, chronic cough, emphysema, difficulty breathing, sever or blood cough
Y N Bleeding disorder, anemia, bleeding tendency
Y N Steroid treatment lasting longer than two weeks
Y N Liver disease, hepatitis
Y N Kidney disease or infections
Y N Thyroid disease, goiter
Y N Arthritis
Y N Stomach ulcers, colitis, bloody stools
Y N Glaucoma
Y N Frequent mouth sores
Y N Artificial joints
Y N Radiation treatment
Y N Sinus infections, sinus surgery
Y N Any disease or medications that depress your immune system
Y N Recurrent infections
Y N Chronic medical conditions or diseases
Y N Persistent swollen neck glands
Y N Difficulty swallowing, breathing or speaking
Y N Epilepsy, seizures, stroke or other neurological disorder
Y N Cancer
Y N Unintentional weight loss, loss of appetite, nausea or vomiting
Y N Treatment for osteoporosis / Bisphosphonate therapy
Y N Blood transfusion
Y N Tuberculosis
Y N Hives, rashes, anaphylaxis

Y N Are you allergic to any medications or materials? List:

Y N Do you **smoke** or use **smokeless tobacco**?
Y N Do you drink **alcohol**?
Y N Do you use any recreational or "street" drugs?
Y N Do you have any problem, disease or condition not listed above?

Y N Is there a history of medical problems in your family? List:

Height _____ Weight _____

WOMEN

Y N Are you pregnant or trying to become pregnant?
Y N Are you breastfeeding?

I understand the importance of a truthful health history, to assist the doctor in providing the best possible care. Errors or omissions made in the completion of this form can have adverse consequences. I have provided, and not omitted, complete information.
I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction.

Signature: _____ **Date:** _____

BP: / HR:

Doctor's Notes:

Doctor's Initials: _____