# South Suburban Oral & Maxillofacial Surgeons, Ltd

Nickname: ______________________________ Whom may we thank for referring you to our office? ______________________

Name: ______________________________________________________ Date of Birth: _____________________ Age: _____
Last First M.I.

Address: ____________________________________________________________________________________________________
Street City State Zip Code

Phone: Home # ( ) _____________________ Cell # ( ) ___________________ Work # ( ) ___________________

Weight: ______ Height: ______ Sex: ____ Pharmacy: __________________________

Patient's Dentist: __________________________________ Patient's Physician: ____________________________________

Have you or any member of your family been a patient in this office before? Yes ☐ No ☐

| PLEASE ANSWER ALL QUESTIONS BY CIRCLING Yes (Y) or No (N) | | | All answers are kept confidential | | |
|---|---|---|---|---|---|
| Are you in good health? | Y | N | Frequent or recurring mouth sores | Y | N |
| Any change in your general health in the past year? | Y | N | Sinus or nasal problems | Y | N |
| Date of last Physical Exam: | | | Sleep Apnea or do you wear a CPAP | Y | N |
| Are you under a physician's care for a particular problem? If yes, for what? | Y | N | Any disease, drugs, or transplant operation that may suppress your immune system | Y | N |
| Have you had any serious illnesses, operations or hospitalizations? If yes, describe: | Y | N | Are you taking any medications, pills, drugs, or herbal supplements? If yes, please specify: | Y | N |
| Clicking or popping of jaw joint, pain near ears, difficulty in opening mouth, grind or clench your teeth | Y | N | | | |
| Have you had any adverse effects from dental treatment? | Y | N | Have you taken medications for osteoporosis or prior cancer? | Y | N |
| Do you take an antibiotic before dental procedures | Y | N | Do you take any Blood Thinners? | Y | N |
| **Do you currently have or ever had any of the following** | | | Do you wear contact lenses? | Y | N |
| Rheumatic fever or rheumatic heart disease | Y | N | Recurring infections of any kind? | Y | N |
| High blood pressure | Y | N | Do you use alcohol? | Y | N |
| Congenital heart disease | Y | N | Do you smoke or chew tobacco? | Y | N |
| Stroke | Y | N | Do you use street drugs? | Y | N |
| Kidney disease | Y | N | Have you ever sought professional care for alcoholism or drug abuse? | Y | N |
| Diabetes | Y | N | | | |
| Cardiovascular disease, heart trouble, chest pain, heart attack, heart murmur, coronary artery disease, angina, palpitations, heart surgery, pacemaker installed | Y | N | Do you have any other disease, condition, or problem not listed here that you think the doctor should know about? Specify: | Y | N |
| Lung disease, asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, severe coughing | Y | N | **Are you allergic to or had a bad reaction to** | | |
| Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily | Y | N | Local anesthesia (novocaine, etc.) | Y | N |
| Seizures, convulsions, epilepsy, fainting, dizziness | Y | N | Penicillin, amoxicillin, cephalosporin, or other antibiotics | Y | N |
| Concussion | Y | N | Barbiturates, sedatives, etc. | Y | N |
| Psychiatric treatment, nervous disorder or breakdown | Y | N | Codeine or other pain killers | Y | N |
| Liver disease, jaundice, hepatitis | Y | N | Latex or rubber products | Y | N |
| Glaucoma | Y | N | Other allergies or reactions: | Y | N |
| Thyroid disease | Y | N | Food Allergies: | Y | N |
| Cancer, chemotherapy, radiation treatment | Y | N | **Women** | | |
| Arthritis | Y | N | Are you pregnant or planning pregnancy? | Y | N |
| Stomach ulcers or colitis | Y | N | Are you taking birth control pills? | Y | N |
| Implants placed in your body (heart valve, hip, knee) | Y | N | Are you taking hormone replacements? | Y | N |

I understand the importance of providing truthful health history to assist my doctor in providing the best care possible. The information I have provided here is complete and accurate.

Patient/Guardian's Signature__________________________________________________ Date _____________