Huntsville Oral and Maxillofacial Surgery Associates, P.C., 2314 Pansy Street, Huntsville, Alabama 35801

Patient Name: ______________________________ Date of Birth: ______________

CONFIDENTIAL MEDICAL HISTORY

	Yes	No
Are you under a physicians care or have you been during the past 5 years, including hospitalizations and surgery?	______	______
Are you currently taking any medication(s), including birth control pills, over-the-counter drugs, or herbal preparations?	______	______
Are you now taking or have you ever taken Bisphosphonates such as Zometa, Boniva or Fossamax?	______	______
Do you have any allergies or sensitivity to any drugs or substances such as penicillin, novocaine, aspirin, latex, betadine, eggs or codeine?	______	______
Have you ever bled excessively after a cut, wound, or surgery?	______	______
Have you ever received a blood transfusion?	______	______
Are you taking aspirin, plavix, coumadin or other anticoagulant (blood thinner) medication?	______	______
Do you have morning sleepiness, snoring, or obstructive sleep apnea (OSA) and/or use CPAP?	______	______
Are you subject to fainting, dizziness, nervous disorders, seizures, or epilepsy?	______	______
Have you ever had any breathing difficulty or lung disorder?	______	______
Do you use any tobacco products?	______	______
Have you or any family members ever had any anesthesia problems?	______	______
Do you have heart disease or a history of chest pain, heart catherization or bypass surgery, heart valve replacement, pacemaker, or other surgery?	______	______
Is there anything you would like to discuss alone with the doctor?	______	______
Do you currently use or have a history of using recreational drugs?	______	______

CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE EXPERIENCED:

Rheumatic Fever	Artificial Joints	Seizure Disorder
Rheumatic Heart Disease	Kidney Disease	Liver Disease/Hepatitis
Heart Murmur	Dialysis Shunt	Ulcers
Mitral Valve Prolapse	Anemia	Gastric Reflux
Heart Surgery	Bleeding Disorder	Hiatal Hernia
Artificial Heart Valve	Thyroid Disease	Crohn's Disease
Heart Pacemaker	Anxiety Disorder	AIDS exposure
High Blood Pressure	Diabetes	Arthritis
Low Blood Pressure	Multiple Sclerosis	Lupus
Stroke	Cancer	TMJ Disorder
Asthma	Glaucoma	Fever Blisters
Emphysema	Venereal Disease	Sickle Cell Disease
Hay Fever	Sinusitis	Drug/Alcohol Addiction
Tuberculosis		

Have you ever had a reaction during or following medical or dental treatment or any surgical procedure? _____ Yes _____ No
Describe ____

Women: Are you pregnant or concerned that you might be pregnant? _____ Yes _____ No Number of Weeks _____

List All Allergies ____

List Current Medications ____

List All Previous Surgery ____

I certify that the answers to the above medical health questions are true and correct to the best of my knowledge.

Signature of patient, parent, or guardian ______________________________ Date ______________

Signature of Reviewing Doctor ______________________________ Date ______________