Palmetto Oral and Maxillofacial Surgeons, P.A.

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Name: _____ Date: _____ Chart #: _____

Dentist: _____ Physician: _____

Who referred you to our office: _____

MEDICAL HISTORY

1.	Are you having pain or discomfort at this time?	Yes No
2.	Have you ever had a bad experience in surgery or dental office?	Yes No
3.	Have you been a patient in the hospital during the past 2 years?	Yes No
4.	Have you been under the care of a medical doctor in the past 2 years?	Yes No
5.	Have you taken Zometa (zoledronic acid) or Aredia (pamidronate) as part of cancer treatment?	Yes No
6.	Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by Penicillin, Aspirin, Codeine or any drugs or medicine?	Yes No
7.	Have you ever had any excessive bleeding requiring special treatment?	Yes No

8. Circle any of the following you have had or have at present:

AIDS	Emphysema	Mitralvalve Prolapse
Alcohol Abuse	Epilepsy or Seizures	Nervousness
Allergies or Hives	Fainting or Dizzy Spells	Pain in Jaw Joints
Anemia	Glaucoma	Psychiatric Treatment
Angina Pectoris	Hay Fever	Rheumatic Fever
Appetite Suppressants	Heart Disease or Attack	Rheumatism
Arthritis	Heart Failure	Scarlet Fever
Artificial Heart Valve	Heart Murmur	Sickle Cell Disease
Artificial Joint	Heart Pacemaker	Sinus Trouble
Asthma	Heart Surgery	Stroke
Blood Transfusion	Hemophilia	Thyroid Disease
Bronchitis	Hepatitis A (infectious)	Tobacco Use
Bruise Easily	Hepatitis B (serum)	Treatment of Osteoporosis
Chemotherapy (cancer, leukemia)	Hepatitis C	Tuberculosis (TB)
Cold Sores	Herpes	Ulcers
Congenital Heart Lesions	High Blood Pressure	Venereal Disease
Cortisone Medicine	HIV	X-Ray or Cobalt Treatment
Cough	Kidney Trouble	Yellow Jaundice
Diabetes	Liver Disease	
Drug Addiction	Lupus	

9.	When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired?	Yes No
10.	Do your ankles swell during the day?	Yes No
11.	Do you use more than 2 pillows to sleep?	Yes No
12.	Have you lost or gained more than 10 lbs. in the past year?	Yes No
13.	Do you ever wake up from sleep short of breath?	Yes No
14.	Are you on a special diet?	Yes No
15.	Has your medical doctor ever said you have cancer or a tumor?	Yes No
16.	Do you have any disease, problem or condition not listed?	Yes No
17.	WOMEN: Are you pregnant now?	Yes No

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

_____ DATE

_____ SIGNATURE OF PATIENT, PARENT OR GUARDIAN

Consult for:

OPS:

MEDICATIONS:

ALLERGIES:

Age _____

BP _____

Pulse _____

Temp. _____

Weight _____

Antibiotic _____

Valium _____

Vistaril _____

Initial _____

Latex: yes no

Food: yes no