Medical History

Georgetown Oral and Facial Surgery

Patient:

#	Question	Explanation	Y	N	?	N/A
1.	Are you in good health?		○	○	○	○
2.	Height _____ Weight_____		○	○	○	○
3.	Has there been any change in your oral health?		○	○	○	○
4.	Are you under a physician's care for a particular problem?		○	○	○	○
5.	Have you had any serious illnesses, operations or hospitalizations? If so, describe:		○	○	○	○
6.	DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:		○	○	○	○
7.	Rheumatic fever or rheumatic heart disease?		○	○	○	○
8.	Congenital heart disease?		○	○	○	○
9.	Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, mitral valve prolapse, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker)?		○	○	○	○
10.	Lung disease (asthma, emphysema, chronic cough, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?		○	○	○	○
11.	Neurologic-psychological disorders (convulsions, epilepsy, seizures, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown)?		○	○	○	○
12.	Blood disease (anemia, bleeding tendency, blood transfusion, do you bruise easily)?		○	○	○	○
13.	Liver disease (jaundice, hepatitis)?		○	○	○	○
14.	Kidney disease?		○	○	○	○
15.	Diabetes?		○	○	○	○
16.	Thyroid disease (goiter)?		○	○	○	○
17.	Arthritis?		○	○	○	○
18.	Stomach ulcers or colitis?		○	○	○	○
19.	Glaucoma?		○	○	○	○
20.	Frequent or recurring mouth sores?		○	○	○	○
21.	Implants placed anywhere in your body (heart valve, hip, knee)?		○	○	○	○
22.	Radiation (x-ray) treatment for cancer?		○	○	○	○
23.	Clicking or popping of jaw joints, pain near ear, difficulty opening mouth, grind or clench teeth?		○	○	○	○
24.	Sinus or nasal problems?		○	○	○	○
25.	Any disease drugs, or transplant operation that has depressed your immune system?		○	○	○	○
26.	Marijuana or other "street" drugs?		○	○	○	○
27.	Recurrent infections of any kind?					

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28.	Problems with anesthesia?		○	○	○	○
29.	Porphyria?		○	○	○	○
30.	Problems with tooth extractions?		○	○	○	○
31.	Cancer?		○	○	○	○
32.			○	○	○	○
33.	Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?		○	○	○	○
34.	WOMEN:		○	○	○	○
35.	Are you taking birth control pills?		○	○	○	○
36.	Are you pregnant or planning pregnancy?		○	○	○	○
37.	**IF YES HOW MANY WEEKS?** _____		○	○	○	○
38.	DENTAL HISTORY:		○	○	○	○
39.	When was your last check-up?		○	○	○	○
40.	Were x-rays taken?		○	○	○	○
41.	Do you have sore or sensitive teeth?		○	○	○	○
42.	Do you have any sores, swellings, or fever blisters in your mouth?		○	○	○	○
43.	MEDICATIONS:		○	○	○	○
44.	Are you taking any medications? Please list ALL MEDICATIONS.		○	○	○	○
45.	ALLERGIES:		○	○	○	○
46.	Do you have ANY allergies? Please list all FOOD and DRUG ALLERGIES.		○	○	○	○
47.	OTHER:		○	○	○	○
48.	Do you wish to talk with the doctor privately about anything?		○	○	○	○
49.	HIPAA ACKNOWLEDGEMENT:		○	○	○	○
50.	I have read and received a copy of the Privacy Policy and Procedures for Georgetown Oral and Facial Surgery.		○	○	○	○