OXFORD MAXILLOFACIAL SURGERY CENTER

MEDICAL HISTORY

NAME_____ AGE_____ DATE_____

Do you have or have you ever had any of the following:

	Yes	No
Rheumatic Fever	☐	☐
Heart Trouble	☐	☐
Heart Attack	☐	☐
Heart Surgery	☐	☐
By-Pass	☐	☐
Valve replacement	☐	☐
Mitral Valve Prolapse	☐	☐
Heart Murmur	☐	☐
High Blood Pressure	☐	☐
Liver Disease	☐	☐
Hepatitis	☐	☐
Anemia	☐	☐
Stroke	☐	☐
Epilepsy or Seizures	☐	☐
Fainting Spells	☐	☐
Kidney Disease	☐	☐
Arthritis	☐	☐
Joint Replacement	☐	☐
Diabetes	☐	☐
Asthma	☐	☐
Allergies	☐	☐

Drug Allergies_____

_____

_____

_____

	Yes	No
Iodine Allergy	☐	☐
IV Contrast Dye Allergy	☐	☐
Lung Trouble	☐	☐
Tuberculosis	☐	☐
Blood Disease	☐	☐
Bleeding Trouble	☐	☐
Blood Transfusion	☐	☐
Did you ever have Cortisone?	☐	☐
Women: Date of last menstrual cycle _____		
Do you now have a cold or bronchitis?	☐	☐
Alcohol Abuse	☐	☐
Drug Abuse	☐	☐
Intravenous	☐	☐
Oral	☐	☐
General Anesthesia	☐	☐
When _____		
Thyroid Disorder	☐	☐
Do/Did you smoke?	☐	☐
How much?_____		
When did you stop?_____		
Last Use of Alcohol or Drugs_____		
AIDS or AID related Complex	☐	☐
Do you consider yourself in a high risk group susceptible to AIDS	☐	☐
Have you ever been treated for depression?	☐	☐

Did you ever have an adverse reaction to any medication or anesthetics? YES ☐ NO ☐
Explain: _____

List all medications and drugs you are taking including over-the-counter drugs and herbal remedies.

_____

_____

Have you been under a Physician's care in the past 5 years? YES ☐ NO ☐
Explain: _____

_____

List previous hospitalizations and surgery_____

_____

When did you last eat or drink? _____

Is there any other information that you think the doctor should know? _____

_____

I understand the above questions and certify that to the best of my knowledge the information is correct. I also understand that every medical and surgical treatment is associated with risks and other unknowns.

Signed_____
(Parent or Guardian if patient is a minor)