Midwest Oral & Maxillofacial Surgery, PA
MEDICAL HISTORY FORM

Name _____ Date of Birth _____ Age _____ Weight_____

Please circle if you have had any of the following and answer questions 1 through 11:

Alcoholism	Bronchitis	Heart Disease	Lung Disease	Stroke
Allergies/Hay Fever	Cancer	Heart Murmur	Malignant Hyperthermia	Steroid Treatment
Anemia	Chemotherapy	Heart Valve Replaced	Pneumonia	Thyroid Disease
Angina/Chest Pain	Diabetes	Hemophilia	Psychiatric Disorder	TMJ Disorder
Anxiety Disorders	Drug Dependency	Hepatitis A, B, or C	Radiation Therapy	Tuberculosis
Arthritis	Eating Disorders	High Blood Pressure	Rheumatic Fever	Ulcer
Artificial Joints	Emphysema	HIV/AIDS	Scarlet Fever	Other(s)_____
Asthma	Gastric Reflux	Immunodeficiency	Seizure/Epilepsy	
Bleeding Disorders	Glaucoma	Kidney Disease	Shortness of Breath	
Blood Diseases	Heart Attack	Liver Disease	Sinus Disease	

1. Reason being seen today_____Referring Doctor/Dentist_____

2. Do you have any drug allergies or sensitivities including latex allergy.....Yes No
   If so, please list with reaction _____

3. Are you taking any medications including non-prescription, herbal, or diet pills.....Yes No
   If so, please list the name of medication and reason for use _____
   _____

4. Do you have a medical reason requiring you to pre-medicate before dental procedures.....Yes No

5. Have you had any serious illness, operation or hospitalization within the past 5 years.....Yes No
   If so, please explain _____

6. Have you ever had any abnormal bleeding or needed a blood transfusion.....Yes No
   If so, please explain _____

7. Have you or a relative had any anesthesia complications .....Yes No
   If so, please list _____

8. Do you use tobacco.....Yes No
   ☐ Cigarette _____ Pack/Day _____Years ☐ Chewing Tobacco ☐ Pipe ☐ Cigar

9. Do you use any illegal or recreational drug.....Yes No
   If so, please explain_____

WOMEN:

10. Are you pregnant or trying to become pregnant .....Yes No

11. Are you nursing .....Yes No

I certify that the above information is current and correct and that incomplete or incorrect responses could result in serious complications with my care.

Patient's Signature:_____Date:_____
(Parent or Guardian if under 18 years of age)