Mark I. Degen, D.D.S., M.D., Ltd.
Red Rock Oral & Maxillofacial Surgery Centre
MEDICAL HISTORY FORM

Name:_____ **Date:**_____

Date of Birth:_____ **Sex: M/F** **Height:**_____ **Weight:**_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? Yes No
2. Has there been any change? Yes No
3. My last physical exam was on_____/_____/_____
4. Are you now under the care of a physician ? Yes No
   If so, for what condition?_____
5. The name and address of my physician is:_____
6. Have you had any serious illness, operation, hospitalization within the last past 5 years.? Yes No
   If yes, please list.....
7. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pill?... Yes No
   Please list:_____
8. **Are you taking the following medications?**
   a. Aspirin, Motrin, Other anti-inflammatory medication Yes No
   b. Other anti-inflammatory medication Yes No
      please list _____
   c. Coumadin, Plavix, Lovenox Yes No
   d. other blood thinners Yes No
      please list _____
   e. Vitamin E, Ginkgo Biloba, Ginseng, Garlic pills Yes No

   Bisphosphonates or Osteoporosis Medications
   1. Fosamax (Alendronate), Actonel (Risedronate), Boniva (Ibandronate), Aredia (Pamidronate) Yes No
   2. Zometa (Zoledronate), Didronel (Etidronate), Skelid (Tiludronate) Yes No

   Aminoglycoside derivatives (i.e., Gentamicin, Streptomycin, etc.) Yes No
9. **Do you have or have had any of the following diseases or problems?**
   a. Damaged heart valves, artificial valves or heart murmur Yes No
   b. Rheumatic Heart Disease Yes No
   c. Heart trouble, heart attack, high blood pressure, stroke arteriosclerosis or any other heart condition Yes No
   d. Chest pain upon exertion Yes No
   e. Shortness of breath Yes No
   f. Do your ankles swell Yes No
   g. Allergies Yes No
   h. Sinus trouble Yes No
   i. Asthma or hay fever Yes No
   j. Fainting spells or seizures Yes No
   k. Diabetes Yes No
   l. Hepatitis, jaundice or liver disease Yes No
   m. Thyroid problem Yes No
   n. Respiratory problems, emphysema, bronchitis, etc Yes No
   o. Arthritis or painful, swollen joints including jaw joint (TMJ) Yes No
   p. Stomach ulcer or hyperacidity Yes No
   q. Kidney trouble Yes No
   r. Tuberculosis Yes No
   s. Persistent cough or phlegm that produces blood Yes No
   t. Low blood pressure Yes No
   u. Epilepsy or any other Neurological disorder Yes No
   v. Cancer Yes No
   w. Any disease, drug or transplant operation that depresses your immune system Yes No
   x. Skin Disease Yes No
   y. Mental Illness/Psychiatric Disorders Yes No
10. Have you had abnormal bleeding? Yes No

11. Have you ever required a blood transfusion?.....Yes No
12. Do you have any blood disorder such as anemia?.....Yes No
13. Have you ever had treatment for a tumor or a growth?.....Yes No
14. **Are you allergic to/or have had a reaction to the following:**
  a. Local anesthetic.....Yes No
  b. Penicillin or antibiotics.....Yes No
  c. Sulfa drugs.....Yes No
  d. Barbiturates or sleeping pills.....Yes No
  e. Aspirin.....Yes No
  f. Iodine.....Yes No
  g. Codeine.....Yes No
  h. Latex.....Yes No
  i. Eggs/egg protein.....Yes No
  j. Birds/Birds protein.....Yes No
  k. other.....Yes No

If yes, please list.....

15. Do you smoke or use other tobacco products?.....Yes No
16. Do you consume alcoholic beverages?.....Yes No
17. Have you ever had radiation therapy to your head or neck?.....Yes No
18. Have you had eye surgery within the past year?.....Yes No
19. Have you had any serious trouble associated with previous dental treatment?.....Yes No
  If so, please explain:_____
20. Do you have any other condition or disease you think the doctor should know about?.....Yes No
  If so, please explain:_____
21. Are you wearing contact lenses?.....Yes No
22. Are you wearing removable dental appliances?.....Yes No
23. Do you wish to talk to the doctor privately about anything?.....Yes No
24. Do you have a strong gag reflex?.....Yes No
25. Do you have difficulty breathing through your nose ?.....Yes No
26. Have you had any dental work, in the past year? .....Yes No

If so please list._____

Women

27. Are you pregnant?.....Yes No
28. Do you have problems associated with your menstrual period?.....Yes No
29. Are you nursing?.....Yes No
30. Are you taking birth control pills?.....Yes No

Taking any unprescribed or illegal drugs may seriously interfere with the medications used in anesthesia and may ultimately lead to death. Please advise the doctor if you have used any such drugs in the past, especially within the past 48 hours.

Chief Complaint:_____

I certify that I have read and understand the above. I acknowledge that any questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my Oral and Maxillofacial Surgeon or any member of the staff responsible for any errors or omissions that I may have made in the completion of this from.

Patient's Siganture: _____ **Date:**_____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history:

_____

_____

_____

Significant findings from questionnaire:

_____

_____

Doctors Signature:_____ **Date:**_____

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____