Lake Charles Oral & Facial Surgery, LLC

MEDICAL HISTORY FORM

Name:_____ Date: _____

Date of Birth: ____/____/____ Age:____ Sex: M / F Height:_____ Weight:

Chief Complaint:_____

Who referred you to our office? _____ **Who is your General Dentist?**_____

Who is your Primary Cary Physician?_____

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

1. Are you allergic to or have you had a reaction to:

a. Local anesthetic (novacaine, xylocaine etc)..... Yes No
b. Penicillin/Amoxicillin/Augmentin..... Yes No
c. Sulfa drugs..... Yes No
d. Erythromycin/Azithromycin(Z-Pack)..... Yes No
e. Clindamycin..... Yes No
f. Other antibiotics_____
g. Aspirin or Ibuprofen..... Yes No
h. Iodine..... Yes No
i. Codeine..... Yes No
j. Latex..... Yes No
k. Other medications_____

1. Has there been any change in your health in the past year?..... Yes No
2. My last physical exam was on / /
3. Are you under the care of a cardiologist (heart doctor) or pulmonologist (lung doctor)?..... Yes No
   If so, for what condition(s)? _____
4. Please list all previous operations/surgeries and dates:_____
5. Have you had any serious illness or hospitalization within the past year?..... Yes No
6. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes No
   If yes, please list joint(s) replaced and dates_____
7. Are you taking or have you ever taken medication for osteoporosis: Circle (Fosamax, Actonel, Reclast, Boniva, Prolia) how long? _____ ..... Yes No
8. Are you taking or have you ever taken any medicine(s) for multiple myeloma or metastatic cancer (Zometa, Aredia, Xgeva) ..... Yes No
   If so, for how long: _____
9. Have you ever had radiation therapy to the Head, Neck or Jaw(s) ..... Yes No
10. Are you taking any of the following medications?

__Antibiotics Name/dose_____
__Blood Thinner Circle: Coumadin/Warfarin Plavix Lovenox Xarelto Ticlid Pradaxa Aggrenox
__Oral (pills) Diabetes Medication name/dose:_____
__Insulin, Type and dosage/schedule_____
__Blood pressure medication(s) name/dose: _____

Please list all other medications/dose:

_____

_____

11. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart valve repair..... Yes No
    b. Rheumatic Heart Disease..... Yes No
    c. Heart trouble, heart attack, angina, A-Fib/arrhythmia (irregular heart beat) or any other heart condition?..... Yes No
        1. Chest pain or shortness of breath upon exertion?..... Yes No
        2. Heart or other stents placed?..... Yes No
        3. Do your ankles swell?..... Yes No
    d. Hypertension/High Blood Pressure..... Yes No
    e. Diabetes Mellitus ..... Yes No
        1. Type I (Juvenile Diabetes) ..... Yes No
        2. Type II (Adult onset Diabetes)..... Yes No
    f. Epilepsy or seizure disorder..... Yes No
    g. Bleeding disorder..... Yes No
        If yes, what type_____
    h. Hepatitis, cirrhosis or liver disease..... Yes No
    i. Thyroid problems..... Yes No
    j. Respiratory problems, emphysema, bronchitis, etc..... Yes No
    k. Osteoporosis ..... Yes No
    l. GERD/Acid reflux disease..... Yes No
    m. Renal failure or kidney disease..... Yes No
        If yes, are you currently on dialysis..... Yes No
    n. Are you an organ transplant recipient..... Yes No
        If so, what organ(s) and dates of transplant_____
    o. Anemia?..... Yes No

13. Any history of cancer ? ..... Yes No

If yes, what type(s) _____

14. Have you had any serious trouble associated with previous operation or anesthesia?..... Yes No
    If so, explain:

15. Do you have any other condition or disease you think the doctor should know about?..... Yes No
    If so, explain:
16. Do you smoke?..... Yes No
    How much per day and for how long? ½ Pack 1 Pack 2 Packs _____Years
17. Do you chew/dip smokeless tobacco?..... Yes No
18. Any history of drug or narcotic dependence? ..... Yes No

Women

19. Are you pregnant or trying to become pregnant..... Yes No
20. Do you have problems associated with your menstrual period?..... Yes No
21. Are you breast feeding?..... Yes No
22. Are you taking birth control pills?..... Yes No

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: Patient's Signature:

_____