**LAKESIDE ORAL SURGERY**
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# PATIENT MEDICAL HISTORY

NAME _____ WEIGHT _____ HEIGHT _____ AGE _____

PHYSICIAN _____ PHONE _____ DENTIST _____ PHONE _____

DATE OF LAST PHYSICAL EXAMINATION _____ BLOOD PRESSURE _____

☐ **YES** ☐ **NO** ARE YOU UNDER A PHYSICIAN'S CARE? IF YES, WHY? _____

☐ **YES** ☐ **NO** ARE THERE ANY LIMITATIONS TO YOUR ACTIVITIES? IF YES, WHAT? _____

☐ **YES** ☐ **NO** DO YOU WEAR CONTACT LENS?

☐ **YES** ☐ **NO** ARE YOU PREGNANT OR NURSING?

## HAVE YOU EVER HAD ANY OF THE ILLNESSES BELOW

| | | | | | |
|---|---|---|---|---|---|
| ☐ **YES** | ☐ **NO** | HIGH BLOOD PRESSURE | ☐ **YES** | ☐ **NO** | THYROID DISEASE |
| ☐ **YES** | ☐ **NO** | HEART ATTACK, DISEASE, MURMUR | ☐ **YES** | ☐ **NO** | EPILEPSY OR SEIZURES |
| ☐ **YES** | ☐ **NO** | RHEUMATIC FEVER | ☐ **YES** | ☐ **NO** | ANGINA OR CHEST PAINS |
| ☐ **YES** | ☐ **NO** | PEPTIC ULCER OR STOMACH DISEASE | ☐ **YES** | ☐ **NO** | STROKE |
| ☐ **YES** | ☐ **NO** | KIDNEY DISEASE | ☐ **YES** | ☐ **NO** | ASTHMA |
| ☐ **YES** | ☐ **NO** | GLAUCOMA | ☐ **YES** | ☐ **NO** | EMPHYSEMA OR OTHER LUNG DISEASE |
| ☐ **YES** | ☐ **NO** | COMPLICATIONS WITH TOOTH EXTRACTION | ☐ **YES** | ☐ **NO** | ANEMIA |
| ☐ **YES** | ☐ **NO** | CANCER | ☐ **YES** | ☐ **NO** | CHEMOTHERAPY OR RADIATION THERAPY |
| ☐ **YES** | ☐ **NO** | DIABETES | ☐ **YES** | ☐ **NO** | HEPATITIS |
| ☐ **YES** | ☐ **NO** | LIVER DISEASE | ☐ **YES** | ☐ **NO** | HAVE YOU EVER TESTED POSITIVE FOR HIV/AIDS? |
| ☐ **YES** | ☐ **NO** | EMOTIONAL OR PSYCHIATRIC PROBLEMS, TREATMENT OR COUNSELING | ☐ **YES** | ☐ **NO** | SLEEP APNEA |

## PLEASE ANSWER THE FOLLOWING QUESTIONS

☐ **YES** ☐ **NO** DO YOU HAVE BLEEDING TENDENCY OR PROLONGED BLEEDING AFTER SURGERY?

☐ **YES** ☐ **NO** HAVE YOU EVER HAD AN UNUSUAL REACTION TO AN ANESTHETIC OR DRUGS?

☐ **YES** ☐ **NO** ARE YOU NOW TAKING OR HAVE YOU EVER TAKEN AREDIA, ZOMETA, FOSAMAX, ACTONEL, BONIVA, DIDRONEL, SKELID, OR RECLAST?

☐ **YES** ☐ **NO** DO YOU HAVE ALLERGIES TO DRUGS OR MEDICATIONS, SUCH AS PCN, CODEINE? IF YES, WHAT? _____

☐ **YES** ☐ **NO** HAVE YOU EVER BEEN IN DRUG OR ALCOHOL REHABILITATION/THERAPY?

☐ **YES** ☐ **NO** HAVE YOU USED NONPRESCRIPTION DRUGS OR ALCOHOL IN THE LAST 7 DAYS (ASPIRIN, ALLERGY MEDICATIONS, RECREATIONAL DRUGS)?

☐ **YES** ☐ **NO** ARE YOU NOW TAKING ANY PRESCRIPTION MEDICATIONS (INCLUDING BIRTH CONTROL PILLS)?

☐ **YES** ☐ **NO** HAVE YOU EVER HAD TMJ PROBLEMS (CLICKING, POPPING, LIMITED OPENING, PAIN IN JAW JOINTS OR MUSCLES)?

☐ **YES** ☐ **NO** ANY OTHER INFO. ABOUT YOUR HEALTH WE SHOULD KNOW? IF YES, WHAT? _____

CURRENT MEDICATIONS? _____ DOCTOR'S NOTES _____

TOBACCO? _____ ALCOHOL? _____

## MEDICAL INFORMATION CERTIFICATION

I hereby certify that the information listed above which I have provided regarding the medical history and status of _____ is complete, true and correct and may be relied upon for all purposes by L. Cowden III D.D.S, E. Frye, D.D.S., any assistants, colleagues, staff and employees, and any other persons treating or assisting in the treatment of the patient.

SIGNATURE _____ RELATIONSHIP _____

DATE _____ WITNESS _____