Champlain Valley Oral & Maxillofacial Surgery, PC
Medical History Form

Name_____ Date of Birth_____ Today's Date_____

Height_____ Weight_____ Referred By_____

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. **Are you now under the care of a physician?** Yes No
   If yes, for what condition? _____
3. **Have you had previous surgery or hospitalizations?** Yes No
   If yes, for what condition? _____
4. **My last physical exam was on**: _____
5. **Please list <u>ALL</u> medications or attach list (Prescription, Non-prescription, Vitamins, and Herbal Medications):**
   _____ _____
   _____ _____
   _____ _____

*****Are you currently taking or have ever taken the following drugs for treatment of osteoporosis or bone disease? Fosamax, Aredia, Zometa? Yes No**

6. **Do you have or have you had any of the following diseases or problems? (Please check all that apply)**

[] Damaged Heart Valves	[] Neurological Problems	[] Persistent Swollen Neck Glands
[] Artificial Heart Valves	[] Fainting Spells	[] Thyroid Problems
[] Heart Attack	[] Seizures	[] Hepatitis
[] Heart Murmur	[] Asthma	[] Jaundice
[] Angina	[] Emphysema	[] Liver Disease
[] Rheumatic Heart Disease	[] Bronchitis	[] Diabetes
[] Other Heart Condition	[] Tuberculosis	[] Stomach Ulcer
[] Arteriosclerosis	[] Persistent Cough	[] Hyperacidity
[] High Blood Pressure	[] Cough Producing Blood	[] Kidney Trouble
[] Low Blood Pressure	[] Arthritis	[] Cancer _____
[] Stroke	[] Painful, Swollen Joints	[] Mouth Sores
[] Problems with Mental Health	[] Total Joint Replacement	

[] Problems, treatments or medications which may have depressed your immune system

7. **Are you allergic to or have you had a reaction to? (Please check all that apply)**

[] Local Anesthetics	[] Antibiotics _____	[] Sulfa Drugs
[] Barbiturates or Sleeping Pills	[] Aspirin	[] Iodine
[] Codeine/Narcotics	[] Latex	[] Other_____

8. **Do you have or have you ever had? (Please check all that apply)**
   [] Prescription medication for weight reduction (Diet Pills)? ____Fen-Phen ____Pondimin ____Redux
   Have you had a medical exam to insure that your heart valves were not affected? Yes No
   [] Problems with previous Dental Treatment [] Smoke or use tobacco products
   [] Alcohol or substance abuse history [] Removable dental appliances
   [] Pain, clicking, locking or popping in your jaw [] Contact Lenses
   Do you have a condition or concern that you wish to discuss with the doctor privately? Yes No
9. **Is there a condition or disease you think the doctor should know about?** Yes No

<u>Women: Are You:</u>

[] Pregnant [] Nursing [] Taking Birth Control Pills [] Having problems with your menstrual cycle

Chief Dental Complaint_____

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

_____ _____ _____ _____

Signature of Patient, Parent or Legal Guardian Date Attending Doctor Signature Date

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