

ADVANCED ORAL SURGERY OF THE FINGER LAKES: Medical History and Evaluation

Name: _____ **Gender:** M F **Date of Birth:** _____ **Age:** _____

<i>Do you/Have you ever had:</i>	YES	NO	DOCTOR'S NOTES:
Recent Illness/Cough/Cold	_____	_____	_____
Nasal Obstruction	_____	_____	_____
Heart Problems/Murmur	_____	_____	_____
Blood Thinners	_____	_____	_____
Artificial Heart Valve/Pacemaker	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Chest Pain	_____	_____	_____
Shortness of Breath	_____	_____	_____
Swollen Ankles	_____	_____	_____
High Blood Pressure	_____	_____	_____
Ulcer	_____	_____	_____
Anemia	_____	_____	_____
Bleeding Problems	_____	_____	_____
Diabetes	_____	_____	_____
Low Blood Sugar	_____	_____	_____
Kidney Disease	_____	_____	_____
Liver Disease	_____	_____	_____
Emphysema	_____	_____	_____
Asthma/ Bronchitis	_____	_____	_____
Stroke	_____	_____	_____
Seizures	_____	_____	_____
Arthritis	_____	_____	_____
Psychiatric Treatment	_____	_____	_____
Hepatitis	_____	_____	_____
HIV/ AIDS	_____	_____	_____
TB	_____	_____	_____
Cancer	_____	_____	_____
Radiation/Chemotherapy	_____	_____	_____
Artificial Joints, Plates, Screws, or Pins	_____	_____	_____
Eye Surgery	_____	_____	_____
Birth control pills	_____	_____	_____
Do you smoke?	_____	_____	<u>If yes, how much do you smoke?</u>
Do you use alcohol/drugs?	_____	_____	<u>If yes, how much?</u>
Are you pregnant/nursing?	_____	_____	_____
Take Bisphosphonates	_____	_____	<u>Fosamax, Actonel, Boniva, Zometa, Xgeva, Reclast, Prolia</u>
Allergies To: Penicillin	_____	_____	Please list any medications you are taking and dosage: _____ _____ _____ _____
Codeine	_____	_____	
Aspirin	_____	_____	
Demerol	_____	_____	
Latex	_____	_____	
Shellfish	_____	_____	
Peanuts	_____	_____	
Other DRUG allergies?	_____	_____	Do you have any other medical problems not listed here? _____ _____
Other allergies?	_____	_____	

Your Height: _____ **Your Weight:** _____

Previous Surgery Type: _____ **Date:** _____

Your Physician: _____ **Your Dentist:** _____

Signature: _____ **Date** _____ I have been offered a copy of the HIPPA Notice of Privacy Practices: _____ Accept O Decline O