



Drs. Posek, Donlevy, and Ying

Oral and Maxillofacial Surgery • Dental Implants

Medical History Questionnaire

Date _____ Patient's Name _____ Age _____

There are many situations which can affect or be affected by the procedure or drugs used during your treatment in our office. Please fill out the following medical history questionnaire carefully and accurately. Please circle all Yes and No answers. Thank you.

1) What prescription, nonprescription, or herbal medications are you currently taking? _____

2) Please list any **ALLERGIES** or sensitivity to any medications, injections, or latex. _____

3) Has there been any change in your health in the last six months? **No Yes** if yes, explain _____

4) Have you ever been hospitalized? **No Yes** if yes, for what reason? _____

5) Have you ever had surgery requiring a general anesthetic? **No Yes** Any complications with anesthesia? **No Yes**

Please list previous surgeries _____

Have you within the last 6 months taken any of the following medications?

- YES NO** Diabetes Medications (Insulin, etc.)
- YES NO** Steroids (Cortisone, Prednisone, etc.)
- YES NO** Bisphosphonates (Fosamax, Actonel, Aredia, Zometa, Boniva, etc.)
- YES NO** Blood Thinners (Plavix, Coumadin, etc.)
- YES NO** Recreational Drugs (Cocaine, Marijuana, Ecstasy, Heroin, etc.)

Women:

- Is there any possibility that you are pregnant?
NO
YES – please notify a staff member immediately
- Are you currently breastfeeding? **YES NO**
- Are you taking birth control pills? **YES NO**

Please circle any of the following conditions that you have had or currently have?

- | | | | |
|-------------------------|---------------------|---------------------|--------------------------|
| Artificial Heart Valve | Epilepsy | Hormonal Disorders | Hip or Joint Replacement |
| Heart murmur | Bleeding Problems | Stomach Ulcer | Obstructive Sleep Apnea |
| Rheumatic Heart Disease | Diabetes | AIDS or HIV | Malignancies/Cancer |
| Rheumatic Fever | Kidney Disease | Glaucoma | Radiation Treatment |
| Heart Attack | Liver Disease | Arthritis | Chemotherapy |
| High Blood Pressure | Jaundice, Hepatitis | Stroke | TMJ (Jaw Joint) Problems |
| Asthma | Thyroid | Shortness of Breath | Chest Pain/Angina |
| Tuberculosis | COPD/Emphysema | Sinus Problems | Psychiatric Treatment |
| Malignant Hyperthermia | Other _____ | | |

Has anyone in your family had any of the following?
 Do you smoke? **No Yes** How much? _____ pack/day How many years? _____
 Number of alcoholic drinks a day _____
 Do you wear contact lenses? **No Yes**

- YES NO** Heart Disease
- YES NO** Bleeding Problems
- YES NO** Anesthetic Complications
What? _____

If you are scheduled for surgery today, what time was the last time you had anything to eat or drink, including water? _____

Who will be driving you home? _____ phone # _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

Signature of patient (Parent or guardian if patient is a minor) _____ Date _____

History reviewed by _____
 RB WC CC

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