Western Branch
Oral and Maxillofacial Surgery

Medical History Form **Dr. Brian Szakaly D.D.S.**

Name: _____ Sex M/F Date: _____

Date of Birth_____ Age_____ Height _____ Weight _____

General Dentist _____ Referral Source (if different from dentist) _____

Occupation _____

Reason for visit today/chief dental complaint

_____

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

1. My last physical exam was on _____/_____/_____
2. Are you under the care of a physician? Yes No
3. The name of my physician is _____
4. Have you had any serious illness, operation or hospitalization within the past five years. Yes No
5. Have you had an artificial joint replacement (knee, hip, shoulder, etc.) Yes No
6. Do you have a serious congenital heart condition Yes No
7. Do you have a history of infective endocarditis Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis? Yes No
   or chemotherapy for multiple myeloma or other cancers (Fosamax, Actonel Yes No
   Boniva, Aredia, or Zometa?
9. Do you have or have you had any of the following diseases or problems? Yes No
   Damaged heart valves, artificial valves or heart murmur Yes No
   Heart attack, angina, high blood pressure. Stroke Yes No
   Arteriosclerosis, cholesterol problems or any other heart condition. Yes No
   (please circle all that apply)
   a. Damaged heart valves, artificial valves or heart murmur Yes No
   b. Heart trouble, heart attack, angina, high blood pressure, stroke, Yes No
      Arteriosclerosis cholesterol problems or any other heart condition
      (Please circle all that apply)
      1. Chest Pain upon exertion? Yes No
      2. Shortness of breath after mild exercise Yes No
   c. Asthma or hay fever Yes No
   d. Respiratory problems, emphysema, bronchitis, tuberculosis, etc. Yes No
   e. Persistent cough or cough that produces blood Yes No
   f. Sleep Apnea Yes No
   g. Persistent swollen neck glands Yes No
   h. Fainting spells Yes No
   i. Epilepsy or neurological disorder Yes No
   j. Diabetes Yes No
   k. Hepatitis, jaundice or liver disease Yes No
   l. Thyroid problems Yes No
   m. Arthritis or painful, swollen joints including jaw joint (TMJ) Yes No
   n. Osteoporosis Yes No
   o. Stomach ulcer or hyperacidity Yes No

p. Kidney trouble Yes No

q. Any disease, drug or transplant operation that has depressed your immune system? Yes No

10.Have you had abnormal bleeding? Yes No

a. Have you ever required a blood transfusion? Yes No

11.Do you have any blood disorder such as anemia (including sickle cell anemia) Yes No

12. Have you ever had treatment for a tumor/growth (i.e. cancer)? Yes No

13. Have you had radiation therapy to the head neck or jaws? Yes No

Please list which one:

14. Are you taking any of the following medications: Yes No _____

a. Antibiotic or sulfa drug Yes No _____

b. Anticoagulants (blood thinners) Yes No _____

c. Medication for high blood pressure Yes No _____

d. Cortisone (steroids (including prednisone) Yes No _____

e. Tranquilizers Yes No _____

f. Aspirin, ibuprofen (Advil or Motrin) Yes No _____

g. Insulin Yes No _____

h. Digitalis (Drugs for heart failure) Yes No _____

i. Nitroglycerin Yes No _____

j. Antihistamine Yes No _____

k. Other (inc diet pills, herbal, homeopathic or etc.. Yes No _____

l. Please list all other medications taking:_____

_____

15. Are you allergic to any of the following medications or products?

Local Anesthestics	Yes	No	Sulfa Drugs	Yes	No
Penicillin or antibiotics	Yes	No	Barbiturates or sleeping Pills	Yes	No
Aspirin	Yes	No	Iodine	Yes	No
Codeine or other narcotics	Yes	No	Latex or rubber products	Yes	No

Other?_____

16. Have you had any serious trouble associated with previous dental treatment? Yes No

If so explain: _____

17. Do you have any other condition or disease you think the doctor should know about? Yes No

If so, explain _____

18. Do you have a nervous/psychiatric condition (including depression/anxiety)? Yes No

If so please explain; _____

19. Do you have a sexually transmitted disease? (Gonorrhea,syphilis,genital warts, HIV, AIDS? Yes No

20. Do you smoke or chew tobacco? Yes No 21. Do you drink alcohol beverages? Yes No

22. are you wearing removable dental appliances? Yes No

Women:

24. Are you pregnant or trying to become pregnant Yes No 25. Do you have problems with your menstrual period?Yes/No

26. Are you nursing? Yes No 27. Are you taking oral contraceptive/hormonal therapy?Yes/No

Do you wish to talk with the doctor privately? 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.

Patient Signature_____ Physician's Signature _____