FAIRFIELD ORAL & MAXILLOFACIAL SUGERY

Patient Name_____Today's Date_____
Age_____Sex: M F Birthdate__/__/__ SS#_____ Marital Status_____
Address_____
City_____State_____Zip_____Phone_____
Employer_____Work Phone_____
Dental Insurance_____Medical Insurance_____
Family Physician_____General Dentist_____Referred by_____
Emergency Contact_____Phone_____Relation_____

Have you had any serious illnesses, surgical procedures, or hospitalizations?_____
_____
Are you currently under the care of a physician? If yes, please explain_____
_____
Please list all medications and herbal supplements_____
_____
Reviewed by _____

Are you allergic to or have had a bad reaction to any of the following:

Antibiotics	Y	N	Aspirin or Ibuprofen	Y	N
Local Anesthesia	Y	N	Latex	Y	N
General Anesthesia	Y	N	Any food allergies	Y	N
Pain Meds	Y	N	Any other allergies	Y	N Please List_____

Have you had any of the following medical conditions?

Heart trouble/Chest pain	Y	N	Stomach problems	Y	N
Heart Attack	Y	N	Kidney problems	Y	N
Heart Murmur	Y	N	Liver problems	Y	N
Coronary Artery disease	Y	N	Lung disease	Y	N
Angina/Palpitations	Y	N	Osteoporosis	Y	N
Heart Surgery	Y	N	Arthritis/Rheumatism	Y	N
Pacemaker	Y	N	Diabetes	Y	N
High/Low blood pressure	Y	N	Asthma	Y	N
Rheumatic Fever	Y	N	Excessive Bleeding	Y	N
A tumor or cancer that			Thyroid Disease	Y	N
Required radiation or chemo	Y	N	Glaucoma	Y	N
Anemia	Y	N	Stroke	Y	N
Leukemia/Lymphoma	Y	N	STD	Y	N
Blood Transfusion	Y	N	HIV	Y	N
Artificial joints	Y	N	Hepatitis	Y	N
Heart Valve Replacement	Y	N	Tuberculosis	Y	N
Seizure	Y	N	Taking blood thinners	Y	N

Are your taking any bone/calcium medications like Fosamax or other bisphosphonates
Y N If yes please list name of medications_____
Do you consume alcohol Y N How much per week?_____
Do you smoke? Y N if yes How much per day_____for how long_____
Circle the most physical activity you can do:
Personal care washing dishes vacuuming mow/rake climb stairs swim run