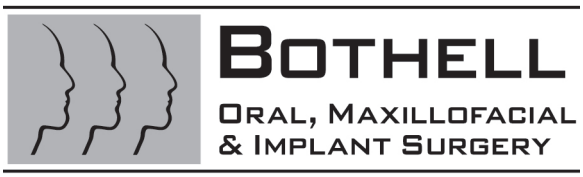

Medical History

18807 Beardslee Blvd., Suite 102
Bothell, WA 98011
Phone: (425) 489-8274
FAX: (425) 487-9506

Name: _____ Title: _____ Date: _____/_____/_____

Birth Date: _____/_____/_____ Age: _____ Height: ___ Weight: _____

Your medical history is very important to us. During the course of your routine care, your surgeon may prescribe antibiotics, pain medication, anti-inflammatory agents, antihistamines, as well as administer local anesthetics, sedatives, narcotics, steroids or several other types or combinations of drugs that may affect your health and wellbeing. No medications are administered without your express permission. It is very important to answer all questions truthfully and to the best of your knowledge to help plan your individual treatment and avoid any unnecessary personal health risks.

How would you estimate your general health? _____

Do you have any medical problems that you think your surgeon should be aware of?

_____

Who is your personal physician? _____Telephone: _____

Are you presently under care for a medical problem? Y N

Date of last physical exam: ____/____/___ Reason for physical exam: _____

Please list your medications: _____ For:_____

_____ For:_____

_____ For:_____

_____ For:_____

_____ For:_____

Have you had any serious illnesses, operations, or hospitalizations in the last two years?

Y N Please describe:

_____

Your surgeon will discuss anesthesia options with you during your consultation.

Do you prefer to be: Awake For Your Surgery Asleep For Your Surgery

Allergies or bad reactions to medications:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Have you or a family member ever experienced a bad reaction to general anesthesia? Y N

Please Describe: _____

See Over Please

The following questions are critical if you are contemplating a general anesthetic or are being evaluation for a pathologic lesion:

Have ever smoked? Y N Presently Smoke Y N Packs per day _____ Years __

Do you drink alcohol? Y N Have you ever been treated for drug or alcohol abuse? Y N

Have you ever abused: Cocaine Heroine LSD Marijuana Meth _____

Have you ever had: Joint Replacement Heart Surgery Pacemaker Artificial Valve

Have you ever been at risk of or tested for: HIV (AIDS) Hepatitis TB CMV

Have you ever had a problem with bleeding after oral surgery / tooth extraction? Y N

Have you ever had or been treated for any of the following diseases (please circle):

Depression	Kidney Dialysis	Neck/Back Surgery	Cancer
Bipolar Disorder	Liver Disease	Sleep Apnea	Radiation Therapy
Neurologic Disorder	Jaundice	CPAP	Osteoporosis
Multiple Sclerosis	Anemia	Bronchitis	Osteopenia
Anxiety	Blood Transfusion	Emphysema	Scoliosis
Epilepsy	Stomach/Gastric Surgery	Shortness Of Breath	TM Joint Disorders
Stroke / TIA	Ulcers/Colitis	Glaucoma	Ibuprofen Allergy
Migraine Headaches	Crohn's Disease	Facial Trauma	Allergy To Eggs
Mental Disability	Hemophilia	Sinus Disease	Hay Fever
Malignant Hyperthermia	Thrombocytopenia	Heart Murmur	Asthma
Myasthenia Gravis	High Blood Pressure	Mitral Valve Prolapse	Fibromyalgia
Diabetes	Low Blood Pressure	Heart Failure	Chronic Pain
Thyroid Disease	Dizziness/Fainting	Chest Pain	Venereal Disease
Pancreatitis	Splenectomy	Heart Attack	Obesity (Surgery)
Kidney Disease	Arthritis	DVT/Embolism	

Women: Some medications used in Oral and Maxillofacial Surgery will cross the placental barrier and breast milk barrier. Some antibiotics may reduce the effectiveness of birth control pills. Some medications may affect an unborn fetus.

Are you pregnant? Y N Don't Know Are you breast feeding? Y N

Do you take: Birth Control Pills? Y N

Would you like to speak privately with your surgeon about any health issues? Y N

I have read and understand the questions on the health history. I have also had the opportunity to discuss my health history as it applies to my treatment and have answered the questions to the best of my ability.

Signature of Patient or Legal Guardian _____ Date: _____

Surgeon Signature: _____Date:_____ Update: _____