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

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

***Do you/Have you ever had*:**	**YES**	**NO**	**DOCTOR'S NOTES:**
Recent Illness/Cough/Cold	_____	_____	_____
Nasal Obstruction	_____	_____	_____
Heart Problems/Murmur	_____	_____	_____
Artificial Heart Valve?	_____	_____	_____
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	_____	_____	_____
Blood thinners	_____	_____	_____
Birth control pills	_____	_____	_____
Do you smoke?	_____	_____	If yes, how much do you smoke?_____
Are you pregnant/nursing?	_____	_____	_____
Take Bisphosphonates	_____	_____	Fosamax, Actonel, Boniva, Aredia, Zometa, Xgeva, Reclast, Prolia

Allergies To: Penicillin _____ _____
Codeine _____ _____
Aspirin _____ _____
Demerol _____ _____
Latex _____ _____
Shellfish _____ _____
Peanuts _____ _____

Other DRUG allergies? _____
Other allergies? _____

Please list any medications you are taking and dosage:
_____ _____
_____ _____
_____ _____

Do you have any other medical problems not listed here?
_____
_____

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

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

Vital Signs: (To be completed by Doctor or Medical Staff)
P_____ R_____ T_____ BP_____

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

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