Knox OMS Knoxville Oral & Maxillofacial Surgery

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FOR INTERNAL USE

Date: _____ Chart #: _____

Doctor: _____

MEDICAL HISTORY

Patient Information

Patient Name (Please Print) First: MI: Last:	**Age**	**Preferred Pharmacy**
Referred by:	**Personal Dentist**	**Primary Care Physician**
Name, **Address** and **Phone** of a person outside your household who could help us in contacting you:		
Have **you** or **your relatives** been treated by this office?		

List reason(s) you have been referred to this office:

If Wisdom Teeth - please list symptoms & date symptoms began:

List the surgeries that you have had:

Did you have general anesthesia? ☐ Yes ☐ No

Medicines that you are presently taking (including birth control and any over the counter medicine such as aspirin, nutritional, herbal, or dietary supplement):

What medicines are you allergic to?
Penicillin Aspirin Demerol Codeine Sulfa Others?

Do you have a Latex allergy? ☐ Yes ☐ No

No	Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, for osteoporosis)?
No	Do you drink alcohol?
No	Do you use drugs?
No	Family history of bleeding or anesthesia reactions?
No	Are you being treated by a physician for any illness?
No	Do you wish to talk to the doctor privately about anything special?

Do you have or have you had any of the following:

No	Rheumatic Fever
No	High Blood Pressure
No	Stroke
No	Heart Disease (heart attack, murmur, angina, valve replace-ment, bypass surgery)
No	Lung Disease (asthma, emphysema, TB, etc.)
No	Epilepsy or seizures
No	Diabetes
No	Mental Illness/Handicap
No	Fever Blisters/Cold Sores
No	TMJ (Jaw Point) Problems
No	Bleeding Disorders
No	Have you ever had a Blood Transfusion?
No	Have you had a hip or joint replacement?
No	Immune Diseases
No	Do you smoke cigarettes, cigars, pipes or use smokeless tobacco?
No	Gastrointestinal disease (ulcers, colitis, diverticulitis)
No	Arthritis, if so, **what type:**
No	Kidney Disease
No	Liver Disease
No	Anxiety/Depression
No	Ladies - are you pregnant?

If due to an accident, please fill out this section

Accident Date	**Claim Adjuster's Name**	**Claim Adjuster's Telephone Number**
Claim Adjuster's Address		
Brief Description of Accident		

I understand the information I have provided on this form is essential to determine my surgical needs and that I have answered all questions truthfully. I will report any changes in my health history as soon as possible.

Signed _____ Date _____