Red Rock Oral & Maxillofacial Surgery Center
Mark I. Degen, D.D.S., M.D., LTD

MEDICAL HISTORY FORM

Patient Name:_____ Date of Birth:_____ Date:_____

Physician's Name & #:_____

Height:_____ Weight:_____ Sex: M / F Pharmacy's Name & #:_____

Medications (including non-prescriptions or "natural" remedies):

_____

_____

For the following questions, please circle Yes or No that applies. Your answers are for our records only and will be considered confidential.

Medications:

YES / NO Aspirin, Motrin
YES / NO Other anti-inflammatory:_____
YES / NO Coumadin Plavix, Lovenox, Eliquis, Xarelto
YES / NO Other blood thinners:_____
YES / NO Vitamin E, Ginkgo Biloba, Ginseng, Garlic pills
YES / NO Fosamax (Alendronate), Actonel (Risedronate)
YES / NO Boniva (Ibandronate)/Reclast (ZoledronicAcid)
YES / NO Zometa (Zoledronate), Prolia (Denosumab)

Health History:

YES / NO Are you in good health?
YES / NO Has there been any changes?
YES / NO Any serious illness, operation, hospitalization within the last 5 years?
If yes, explain: _____
YES / NO Damaged/artificial heart valves, heart murmurs
YES / NO Rheumatic Heart Disease
YES / NO Heart Trouble/ Heart Attack
YES / NO High blood pressure, stroke arteriosclerosis
YES / NO Other heart condition:
_____
YES / NO Chest pain upon exertion
YES / NO Shortness of breath
YES / NO Ankles swelling
YES / NO Seasonal allergies
YES / NO Sinus troubles
YES / NO Asthma/Hay fever
YES / NO Fainting spell or seizure
YES / NO Diabetes
YES / NO Hepatitis, Jaundice or Liver disease
YES / NO Thyroid problem
YES / NO Respiratory problems, emphysema, bronchitis, etc.
YES / NO Arthritis or painful, swollen joints, jaw joint (TMJ)
YES / NO Stomach ulcer or hyperacidity
YES / NO Kidney trouble
YES / NO Tuberculosis
YES / NO Persistent cough or phlegm that produces blood
YES / NO Low blood pressure
YES / NO Epilepsy or any other Neurological disorder
YES / NO Cancer
YES / NO Skin disease
YES / NO Mental Illness / Psychiatric Disorder

Health History (continue):

YES / NO Abnormal bleeding
YES / NO Any disease/drug/transplant operation that depresses your immune system
YES / NO Blood Transfusion
YES / NO Blood disorder such as anemia
YES / NO Treatment for a tumor or a growth
YES / NO Do you smoke/use other tobacco products?
YES / NO Do you consume alcoholic beverages?
YES / NO Radiation therapy to your head or neck
YES / NO Eye surgery within the past year
YES / NO Any serious trouble associated with previous dental treatment?
If Yes, Explain: _____
YES / NO Any other condition/disease you think the doctor should know about?
If Yes, Explain: _____
YES / NO Are you wearing contact lenses?
YES / NO Strong gag reflex
YES / NO Any difficulty breathing through your nose
YES / NO Have you or a family member ever had an adverse reaction to General Anesthesia?
If Yes, explain: _____
YES / NO Any dental work in the past year
If yes, Explain: _____

Allergies:

YES / NO Local anesthetic (numbing injection)
YES / NO Sulfa drugs
YES / NO Penicillin or antibiotics
YES / NO Aspirin
YES / NO Codeine
YES / NO Barbiturates or sleeping pills
YES / NO Iodine
YES / NO Latex
YES / NO Eggs / Egg protein
YES / NO OTHER:_____

WOMEN ONLY:

YES / NO Are you pregnant?
YES / NO Problems associated with your menstrual period
YES / NO Are you nursing?
YES / NO Are you taking birth control pills?

Taking any unprescribed or illegal drugs may seriously interfere with the medications used in anesthesia and may ultimately lead to death. Please advise the doctor if you have used any such drugs in the past, especially within the past 48 hours.

I certify that i have read and understand the above. I acknowledge that any questions, if any the inquires set forth above have been answered to my satisfaction. I will not hold my Oral and Maxillofacial Surgeon or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

PATIENT'S SIGNATURE:_____ DATE:_____

DOCTOR'S SIGNATURE:_____ DATE:_____

Comments on patient interview concerning medical history:

_____

_____