Patient Health Form

ORAL MAXILLOFACIAL SURGERY

PROVINCIAL ORAL SURGERY
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Please Complete Information In Full

Full Name: _____
Last *First* *M.I.*

Name of Parent or Guardian: _____
If Patient is under 18 years of age

Age: ____ **DOB:** _____ **Gender:** M F X **Marital Status:** _____ **Height:** _____ **Weight:** _____
Month/Day/Year

Address: _____
Street *Apt/Unit* *City* *Province* *Postal Code*

Phone: _____ **Email:** _____
Cell *Home* *Alternate*

Health Card #: _____ **Supplemental Health/FNIHB:** Y or N #: _____

Physician's Name: _____ **Dentist's Name:** _____

Health History

Last Physical Exam: _____ Last Surgery: _____ Last Hospitalization: _____

Are you in good health? Y / N Are you taking any medications: Y / N List: _____
(Prescription, Non-Prescription, Herbal Medicine, list on back of page if more space needed)

History/Family History of General Anesthesia Problems: Y/ N If so explain: _____

Are you allergic to/have a reaction to any medications (lidocaine, penicillin, aspirin, etc)? _____

Other Allergies (latex, etc)? _____

If yes to Allergies please explain type of allergic reaction: _____

DO YOU USE or HAVE YOU EVER USED:

Tobacco? Y/N	Type:	Years:	Frequency:	Alcohol:	Drinks/week:
Marijuana? Y/N	Type:	Years:	Frequency:		
Illegal Drugs? Y/N	Type:	Years:	Frequency:		

WOMEN ONLY:
Are you pregnant? Y/N Are you trying to get pregnant? Y/N Menstrual Problems? Y/N Birth Control Pills? Y/N

DO YOU HAVE ANY OF THE FOLLOWING *(circle, explain below)*

Damaged Heart Valve	Abnormal Bleeding	Mouth Sores	Persistent Cough	Rheumatic Heart Disease
Artificial Valve	Fainting Spells	Kidney Trouble	Swollen Glands	Blood Transfusions
Heart Murmur	Seizures	Tuberculosis	Low Blood Pressure	Radiation Therapy
Heart Attack	Liver Problems	Respiratory Problems	Transplant Type?	Thyroid Problems
Heart Trouble	Jaundice	Osteoporosis	HIV/AIDS	Anxiety/Depression
High Blood Pressure	Hepatitis(A,B,C)	Ulcer	Sexually Transmitted Disease	Epilepsy
Stroke	Sinus Trouble	Asthma	Cancer	OTHER:
COPD	Type I Diabetes	Hay Fever		
Type II Diabetes	***Explain:***			

Reason for referral to our office: _____ **Referred by**: _____

Disclaimer and Signature

I have read and understand all of the above and have filled out the above information to the best of my knowledge.

Signature: _____ **Date:** _____
Patient Signature / Under 18 years of age Parent/Guardian Signature