



Patient Health Form

PROVINCIAL ORAL SURGERY
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ORAL MAXILLOFACIAL SURGERY

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: _____
Main Home Alternate

Health Card #: _____ Supplemental Health/Indian Affairs: 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)

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