Advanced Oral and Facial Reconstructive Surgery

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MEDICAL HISTORY

Please answer ALL the following questions and fill in the blanks where indicated. This questionnaire is for our records only and will be considered confidential.

Patient Name: _____ Birth Date: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

1. Are you in good health? □ Yes □ No
2. Your last physical examination was on (date): _____
3. Are you under the care of a physician? □ Yes □ No
   If so, what is the condition that is being treated? _____
   Name and telephone number of the physician: _____
4. Do you have a cardiologist? □ Yes □ No
   Name and telephone number of cardiologist: _____
5. Have you had any serious illness, operation, or been hospitalized? □ Yes □ No
   If yes, what was the problem and when?_____
6. Are you pregnant? □ Yes □ No
7. Do you grind your teeth at night? □ Yes □ No
8. Do you have a history of jaw pain when opening and closing? □ Yes □ No
9. Does your jaw pop or click when opening? □ Yes □ No
10. Has your jaw ever been stuck open or closed? □ Yes □ No
11. Do you drink alcoholic beverages? □ Yes □ No
    If yes, how many per week? _____
12. Do you smoke or use tobacco products? □ Yes □ No
    If yes, how many cigarettes per day? _____
13. Do you use any recreational drugs? □ Yes □ No
    If yes, what kind? _____ How many times per month? _____
14. Do you use marijuana? □ Yes □ No
    If yes, how many times per month? _____
15. Do you take vitamins and/or supplements? □ Yes □ No
16. Please list all drugs, medications, or supplements you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

17. Are you taking any of the following? (please check the appropriate boxes)
    - ☐ Antibiotics or sulfa drugs
    - ☐ Anticoagulants (blood thinner)
    - ☐ Aspirin
    - ☐ Cortisone (steroids)
    - ☐ Digitalis or drugs for heart problems
    - ☐ Fish Oil
    - ☐ Insulin
    - ☐ Medicine for anxiety or depression
    - ☐ Medicine for high blood pressure
    - ☐ Nitroglycerin
    - ☐ Tranquilizers
18. Are you taking OR have you ever taken:
    - ☐ Osteoporosis medications (Fosamax, Actonel, Aredia, Boniva, Didronel, Skelid, Bonefos, or Zometa)
    - ☐ PROLIA for osteoprosis, or chemotherapy for Multiple Myeloma, etc
    - ☐ Fen-Phen or related drug such as lonimin, Adipex, Phentramine, Fastin, Pondimin (fenfluramine), and Redux (dexfenfluramine)
19. Please list any medication allergies:

    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
20. Are you allergic or have you reacted adversely to any of the following? (please check the boxes if so)
    - ☐ Aspirin
    - ☐ Barbiturates, sedatives, sleeping pills
    - ☐ Iodine
    - ☐ Latex
    - ☐ Local Anesthetic
    - ☐ Penicillin or other antibiotics
    - ☐ Soybean or egg
    - ☐ Sulfa drugs
    - ☐ Other: _____
21. Have you had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or on your lips? ☐ Yes ☐ No
22. Have you had any adverse reaction associated with previous dental treatment? ☐ Yes ☐ No
    If yes, please explain: _____
23. Have you had any adverse reactions associated with previous medical treatment or surgery?
    ☐ Yes ☐ No
24. Have you had any adverse reaction or family history of adverse reaction to anesthesia? ☐ Yes ☐ No
25. Have you ever received any radiation treatment to the jaws or any area of the head and neck for any reason? ☐ Yes ☐ No
    If yes, what was the body location where radiation was performed? _____
    When was treatment? _____
    Doctor who performed the treatment? _____
26. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
    ☐ Yes ☐ No
27. Do you bruise easily? ☐ Yes ☐ No

28. Have you ever required a blood transfusion? ☐ Yes ☐ No
    If yes, explain circumstances: _____
29. Do you have any bleeding disorder (such as anemia)? ☐ Yes ☐ No
30. Have you had any of the following conditions? (please check the appropriate boxes)

☐ ADHD	☐ Blood Clot	☐ HIV Positive
☐ AIDS	☐ Cancer	☐ Immunosuppression
☐ Allergies	☐ Clotting Disorder	☐ Kidney Disease
☐ Anaphylaxis	☐ Depression	☐ Liver Problem
☐ Anemia	☐ Diabetes	☐ Low Blood Pressure
☐ Angina	Current A1C? _____	☐ Lung Disease
☐ Anxiety	☐ Drug/Alcohol Addiction	☐ Mental Illness
☐ Arthritis	☐ Emphysema	☐ Rheumatic Fever
☐ Artificial Joint Replacement	☐ Epilepsy	☐ Stroke
	☐ Fainting	☐ Thyroid
☐ Asthma	☐ Glaucoma	☐ Tuberculosis
☐ Autism Spectrum Disorder	☐ Heart Attack	☐ Venereal Disease
	☐ Hepatitis	
☐ Bipolar Disorder	☐ High Blood Pressure	

☐ Other: _____

I have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware.

Signature of Patient/Legal guardian: _____ Date: _____

I have reviewed the health history form above.

Signature of Dr. Gilbert Selkin: _____ Date: _____