MEDICAL HISTORY FORM

Wilmington Oral Surgery
Scott A. Puckett, D. D. S.

Name: _____ Date: _____

Date of Birth: _____ Sex: M / F Height: _____Weight: _____

Your answers are for our records only and will be kept confidential.

Chief Concern you would like addressed by the Doctor: _____

1. Do you have any **Medical Conditions ?** .....Yes No
   If so, please list: _____
   _____
2. Do you have any **Allergies (medications, latex, foods)?**..... Yes No
   If so, please list: _____

3. Do you have **Asthma?** .....Yes No
4. Do you **Smoke** tobacco? .....Yes No
5. Have you had an **Artificial joint replacement** (knee, hip, shoulder, etc.)? .....Yes No
   If so, please specify and the date of surgery. _____
   _____

6. Are you **currently taking any Medications** including vitamins/homeopathic medications..... Yes No
   If YES please list, and list dosage if known: _____
   _____
   _____
   _____

   Are you currently taking anticoagulant (blood thinning) medications (Coumadin, Xarelto, Pradaxa, Effient, Eliquis, Aspirin) ? ..... Yes No

   Have you ever taken Bisphosphonates for osteoporosis or chemotherapy (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia)? ..... Yes No

7. Are you now under the care of a physician? ..... Yes No
8. Do you have any of the following diseases or conditions?
   a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
   b. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
      If yes, list name of treating cardiologist _____
   c. Fainting spells or seizures ..... Yes No
   d. Diabetes ..... Yes No
   e. Hepatitis, jaundice or liver disease ..... Yes No
   f. Thyroid problems ..... Yes No
   g. Respiratory problems, emphysema, bronchitis, etc..... Yes No
   h. Arthritis, or painful, swollen joints including jaw joint (TMJ) ..... Yes No
   i. Osteoporosis ..... Yes No
   j. Stomach ulcer ..... Yes No
   k. Kidney trouble ..... Yes No
   l. Tuberculosis ..... Yes No
   m. Cancer ..... Yes No
   n. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No

MEDICAL HISTORY CONTINUED… Name: _____

9. Have you had abnormal bleeding? …… Yes No
   a. Have you ever required a blood transfusion? …… Yes No
10. Have you ever had treatment for a tumor or growth? …… Yes No
11. Have you had radiation therapy to the head, neck or jaws? …… Yes No
12. Have you had any serious trouble associated with previous dental treatment? …… Yes No
    If so, explain: _____
    _____
13. Do you have any other condition or disease you think the doctor should know about? …….. Yes No
    If so, explain: _____
    _____
14. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? …….. Yes No

Women

1. Are you pregnant or trying to become pregnant? …….. Yes No
2. Are you nursing? …….. Yes No
3. Are you taking birth control pills? …… Yes No

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Patient/Guardian Signature: _____Date: _____

Doctor's Signature: _____Date: _____