FACE2FACE
Maxillofacial Surgery Centre

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(708) 755-0800
www.face2facesurgery.com

Medical History Form

Name _____ Date _____ Gender M F O

Email Address _____ Pharmacy Name/Address _____

Date of Birth _____ Height _____ Weight _____ Spouse _____

Address _____

Home # _____ Cell # _____ Guarantor _____ DOB _____

Employer _____ Insurance Co _____ SSN _____

Dentist Name _____ Physician Name _____

Please respond to the following questions regarding your medical health:

1) Date of last physical examination _____

2) Are you being treated for any medical condition? _____

_____

3) Have you had a serious illness, operation or been hospitalized? _____

_____

4) Please list all prescription and non-prescription medications that you are taking (dose and time of day):

_____

_____

_____

_____

5) Are you allergic to or had a reaction to any of the following:

Local Anesthetics	Yes	No
Penicillin Antibiotics	Yes	No
Sulpha Drugs	Yes	No
Sedatives	Yes	No
Aspirin/NSAIDS	Yes	No
Codeine or other Narcotics	Yes	No
Iodine	Yes	No

Do you have any other allergies? _____

6) Do you have any of the following:

a.	Diabetes	Yes	No
b.	Insulin treated diabetes	Yes	No
c.	High blood pressure	Yes	No
d.	Low blood pressure	Yes	No
e.	Cardiovascular disease	Yes	No
f.	Damaged heart valves/rheumatic heart disease	Yes	No
g.	Heart murmur	Yes	No
h.	Stroke	Yes	No
i.	Shortness of breath	Yes	No
j.	Swollen ankles	Yes	No
k.	Inborn heart defects	Yes	No
l.	Cardiac pacemaker/defibrillator	Yes	No
m.	Heart attack	Yes	No
n.	Angina/chest pain	Yes	No
o.	Asthma	Yes	No
p.	Fainting spells	Yes	No
q.	Seizures/epilepsy	Yes	No
r.	Hepatitis/liver disease	Yes	No

s.	AIDS or HIV infection	Yes	No
t.	Thyroid disease or problems	Yes	No
u.	Emphysema/bronchitis/COPD	Yes	No
v.	Arthritis or painful joints	Yes	No
w.	Stomach ulcer/reflux/acidity	Yes	No
x.	Crohn's or colitis	Yes	No
y.	Kidney disease	Yes	No
z.	Persistent swollen glands	Yes	No
aa.	Mental health issues/psychiatric care	Yes	No
bb.	Anxiety disorder/panic attacks	Yes	No
cc.	Attention deficit disorder	Yes	No
dd.	Depression	Yes	No
ee.	Cancer/radiation treatment	Yes	No
ff.	Abnormal bleeding	Yes	No
gg.	Treatment of a tumor or growth	Yes	No
hh.	Osteoporosis/bisphosphonate medicine	Yes	No
ii.	Sleep apnea	Yes	No

7) Do you smoke or use smokeless tobacco? Yes No

a) Are you a former tobacco user? Yes No

b) How many years have/did you use tobacco? _____

c) How much tobacco do/did you use per day? _____

8) Do you use/drink alcoholic beverages? Yes No

a) What type _____

b) How many times per week do you use alcoholic beverages? _____

9) Do you use any illicit street drugs? Yes No

a) What type _____

10) Do you use marijuana or cannabis? Yes No

11) Do you wear contact lenses? Yes No

12) Do you have pain/sounds in your Temporomandibular joints? Yes No

Women

13) Are you pregnant? Yes No

14) Are you nursing? Yes No

15) Are you taking birth control pills? Yes No

I certify that I have read and understand the above questionnaire. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not withhold information regarding my medical health. I will not hold my surgeon/physician or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of the Patient _____

Signature of Guardian/Parent _____ Relationship _____

To be completed by Surgeon

Medical Management issues from questionnaire or oral interview

_____

_____

Date _____ Signature of Surgeon _____

Date _____ Signature of Surgeon _____

Date _____ Signature of Surgeon _____