KENDALL ORAL & MAXILLOFACIAL SURGERY
CONFIDENTIAL MEDICAL INFORMATION

Patient Name________________________ Weight__________ Height__________ Age__________

The following information is essential for this office to provide care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your health needs safely and efficiently. Incorrect information can be dangerous to your health.

	CIRCLE	EXPLAIN IF YES
Are you presently under a physician's care for any illness or problems?	NO YES	
Have you ever had any surgery?	NO YES	
Did you have general anesthesia?	NO YES	
Any previous dental surgery?	NO YES	
Have you ever had any unusual or prolonged bleeding after surgery?	NO YES	
Do you take any medication for osteoporosis? (ex: Fosamax, Boniva, Aredia, Zometa, Actonel).	NO YES	
Rheumatic fever	NO YES	
Heart trouble or Heart attack	NO YES	
Heart murmur	NO YES	
Artificial heart valve or joint.	NO YES	
Blood pressure problems	NO YES	
Stroke	NO YES	
Emphysema, asthma or other lung disease	NO YES	
Diabetes	NO YES	
Cancer	NO YES	
Chemotherapy or radiation	NO YES	
Venereal disease	NO YES	
Hepatitis	NO YES	
Do you have any reason to believe you may be immunosuppressed?	NO YES	
Have you experienced chronic fatigue, night sweats, chronic cough or recurrent mouth sores?	NO YES	
Liver or kidney trouble	NO YES	
Glaucoma	NO YES	
Emotional or psychiatric problems	NO YES	
Tempormandibular joint (TMJ) pain	NO YES	
Do you smoke? How much?	NO YES	
Do you use alcohol?	NO YES	
Are you wearing contact lenses?	NO YES	
Are you taking birth control pills?	NO YES	
Are you pregnant or nursing a baby?	NO YES	
Do you now have a cough or cold?	NO YES	
Are you allergic to any drugs? List	NO YES	
Do you use aspirin? How much?	NO YES	
Have you ever had any unusual reaction to any drugs?	NO YES	
Are you taking blood thinners? (Anticoagulants)	NO YES	
Do you wish to speak to the doctor in private about anything?	NO YES	

What medications are you now taking, including herbal supplements?________________________

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List other important information about your health that we should know:________________________

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SIGNATURE________________________ DATE__________