

COLUMBIA BASIN ORAL AND MAXILLOFACIAL SURGEONS

512 North Young Street, Kennewick, WA 99336

(509) 783-7600

MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

DO YOU HAVE ANY ALLERGIES OR ARE YOU SENSITIVE TO ANY DRUGS OR MEDICINES (SUCH AS PENICILLIN, NOVOCAINE, ASPIRIN, CODEINE, OR ANY OTHER?) \_\_\_\_\_

ARE YOU TAKING (OR SUPPOSED TO BE TAKING) ANY MEDICINE, DRUGS, OR PILLS OF ANY KIND? IF YES, WHAT KIND AND DOSE: \_\_\_\_\_

DO YOU TAKE OR HAVE YOU TAKEN:

Bisphosphonate Medications Y N \_\_\_\_\_ (ACE) Angiotension Converting Enzyme Inhibitor Y N \_\_\_\_\_

Please answer ALL questions by circling (Y) yes or (N) no for any condition which you have now OR in the past. Parent or Guardian: if you are completing this form for your child, please indicate your child's health status by circling the appropriate answer.

**CARDIOVASCULAR**

- Y N....Heart Disease or Attack
- Y N....Angina Pectoris or Chest Pain
- Y N....High Blood Pressure
- Y N....Heart Murmur
- Y N....Rheumatic Fever
- Y N....Congenital Heart Defect or Lesion
- Y N....Artificial Heart Valve
- Y N....Heart Pacemaker
- Y N....Heart Surgery or Transplant
- Y N....Stroke
- Y N....Aneurysm
- Y N....Other \_\_\_\_\_

**HEMATOLOGIC**

- Y N....Blood Transfusion
- Y N....Anemia
- Y N....Hemophilia
- Y N....Leukemia
- Y N....Sickle Cell (Anemia) Disease
- Y N....Tendency to Bleed Longer than Normal or Bruise Easily

**NEURAL/SENSORY**

- Y N....Eye Pain
- Y N....Vision Problems/Contact Lenses
- Y N....Glaucoma or Cataract
- Y N....Earaches, Ringing in Ears
- Y N....Hearing Loss
- Y N....Severe Headaches
- Y N....Fainting or Dizzy Spells
- Y N....Epilepsy, Seizures, or Convulsions
- Y N....Nervousness
- Y N....Psychiatric Treatment

**GASTROINTESTINAL**

- Y N....Stomach or Intestinal Ulcers
- Y N....Gastritis
- Y N....Colitis
- Y N....Persistent Diarrhea
- Y N....Hepatitis
- Y N....Liver Disease
- Y N....Yellow Jaundice
- Y N....Cirrhosis

**RESPIRATORY**

- Y N....Hay Fever
- Y N....Sinus Trouble
- Y N....Allergies or Hives
- Y N....Asthma
- Y N....Chronic Cough
- Y N....Emphysema/Pneumonia
- Y N....Tuberculosis (TB)
- Y N....Breathing Difficulties

**DERMAL/SKIN/JOINTS**

- Y N....Skin Rash
- Y N....Dark Mole(s)  
(recent change in appearance)
- Y N....Night Sweats
- Y N....Sore Muscles
- Y N....Stiff Joints
- Y N....Arthritis
- Y N....Artificial Joint
- Y N....Fever Blisters
- Y N....Mouth Ulcers or Canker Sores
- Y N....Colored or Discolored Areas in Mouth

**ENDOCRINE**

- Y N....Diabetes
- Y N....Thyroid Disease

**URINARY**

- Y N....Urinate Frequently
- Y N....Kidney, Bladder Problems
- Y N....Sexually Transmitted (Syphilis, Gonorrhea, Chlamydia, Genital herpes or any other?)

**OTHER CONDITIONS**

- Y N....Frequent Sore Throats
- Y N....Enlarged Lymph Node or "Gland"
- Y N....Use Tobacco (Chew/Smoke)
- Y N....Use Alcohol
- Y N....Drug Use
- Y N....Tumor or Cancer
- Y N....Chemotherapy
- Y N....Radiation Treatment
- Y N....History of Jaw Joint Problems (clicking, Locking or Pain)
- Y N....Sensitivity to Rubber or Latex

DO YOU HAVE ANY OTHER DISEASE OR MEDICAL CONDITIONS THE DOCTOR SHOULD KNOW ABOUT? \_\_\_\_\_

(CONTINUED ON BACK)