Pre-Oral Surgery Medical History Form

Personal Information

Full Name

Date of Birth

Address

Phone Number

Email

Emergency Contact Name

Emergency Contact Phone

Relationship to Emergency Contact

Medical History

Are you under a physician’s care?

Yes

No

If yes, please specify

Have you ever been hospitalized or had a major operation?

Yes

No

If yes, please specify

Have you had any allergic reactions? (medications, food, latex, etc.)

Yes

No

If yes, please list

List any medications you are currently taking

Do you smoke or use tobacco?

Yes

No

Do you consume alcohol?

Yes

No

Health Conditions

Please check any medical conditions that apply:

Heart Disease

Diabetes

High Blood Pressure

Blood Thinners

Asthma

Kidney Disease

Liver Disease

Bleeding Disorders

Pregnancy

Other

If other, please specify

Additional Information

Any concerns or information your surgeon should be aware of?

Signature

Date