Dr. Denis Nagy, B.Sc., M.Sc., D.D.S., M.D., F.R.C.D.(C)

Oral and Maxillofacial Surgery

• MEDICAL - HEALTH HISTORY ACQUAINTANCE •

The information collected from you on all our confidential forms is essential for providing the safest professional care

Please Print **Month:** **Day:** **Year:**

Patient

Legal LAST NAME | **Legal FIRST NAME** | M. Initial | Preferred name / goes by

Gender M F | **Age** | **Patient Date of Birth:** Month: Day: Year: | **HEIGHT:** **WEIGHT:**

• Patient's Physicians or walk-in clinic used:

Name: Telephone: Name: Telephone:

• Patient's preferred pharmacy: Telephone:

• Have any other family members or friends been treated at our practice? *If yes, please provide name(s):*

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1. **Please list all medications you are taking including: prescription, non-prescription, herbal supplement, holistic, vitamin, steroid, other:** **MEDICATIONS**

2. **Please list all known allergies / sensitivities including: medication, food, chemical, latex, other:** **ALLERGIES**

3. **Do you have, or are there any inherited anesthesia problems in your family?** **YES** **NO**
   example: malignant hyperthermia
4. **Have you ever experienced nausea after intravenous sedation (IV Sedation)?** **YES** **NO**
5. **Do you have, or are there any inherited bleeding problems in your family?** **YES** **NO**
6. **Do you have obstructive sleep apnea / CPAP ?** **YES** **NO**
7. **Do you have any sinus or nasal problems - nose bleed history?** **YES** **NO**
8. **Do you have any neck mobility limitations?** **YES** **NO**
9. **If you are in a wheelchair, are you able to transfer to a dental chair?** **N/A** **YES** **NO**
10. **Do you smoke or use other forms of tobacco, including marijuana, e-cigarettes/vape?** **YES** **NO**
11. **Have you used any recreational drugs in the last 48 hours?** **YES** **NO**

12. **MEDICAL HISTORY: have you had, or are you being treated for any of the following:**

HEART ATTACK Date of event:	**YES**	**NO**
ANGINA / CHEST PAIN	**YES**	**NO**
PACEMAKER Date placed:	**YES**	**NO**
RECENT STROKE / TIA'S Date of event:	**YES**	**NO**
CONGENITAL HEART LESIONS	**YES**	**NO**
ARTIFICIAL / MECHANICAL HEART VALVE	**YES**	**NO**
ASTHMA / CHRONIC LUNG DISEASE / CHRONIC COUGH	**YES**	**NO**
KIDNEY DISEASE / DIALYSIS	**YES**	**NO**
DIABETES Any Insulin requirement?:	**YES**	**NO**
BLOOD DISORDERS example: low platelets, anemia, neutropenia, hemophilia	**YES**	**NO**
HEPATITIS A B C - HIV / AIDS - OTHER	**YES**	**NO**
CANCER / TUMORS	**YES**	**NO**
Are you now, or have you ever taken BISPHOSPHONATES for osteoporosis or cancer?	**YES**	**NO**
HEAD & NECK RADIATION Location :	**YES**	**NO**
SEIZURES / HEAD INJURY / RECENT CONCUSSION	**YES**	**NO**
ARTIFICIAL JOINTS	**YES**	**NO**
TEMPOROMANDIBULAR JOINT (TMJ) problems	**YES**	**NO**

13. **Female Patients:** a. Are you taking birth control pills? **N/A** **YES** **NO**

b. Are you pregnant? **YES** **NO**

14. **Do you have, or have you had any medical conditions or health concerns not listed?** **YES** **NO**

15. **Is there anything you wish to discuss privately?** **YES** **NO**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Dr. Nagy or his team of any changes in medical status.

Completed: • **DATE: X** month: day: year:

Patient Parent / Guardian • **SIGNATURE: X**