PRESTIGE®
ORAL & FACIAL SURGERY CENTER

5925 CROMO DR. STE. B, EL PASO, TX 79912 P: (915) 283-4730 | F: (915) 283-6210

MEDICAL HISTORY FORM

11. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
12. Do you have any blood disorder such as anemia? ..... Yes No
13. Have you ever had treatment for a tumor or growth? ..... Yes No
14. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
15. Are you allergic to or have you had a reaction to:
    a. Local Anesthetics ..... Yes No
    b. Penicillin or Antibiotics ..... Yes No
    c. Sulfa Drugs ..... Yes No
    d. Barbiturates or Sleeping Pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or Other Narcotics ..... Yes No
    h. Latex or Rubber Products ..... Yes No
    i. Other ..... Yes No
16. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____
17. Do you have any other condition or disease you thing the doctor should know about? ..... Yes No
    If so, explain: _____
18. Do you smoke or chew Tobacco? ..... Yes No
    How much? _____
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Yes No
20. Are you wearing contact lenses? ..... Yes No
21. Are you wearing removable dental appliances? ..... Yes No
22. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

23. Are you pregnant or trying to become pregnant ..... Yes No
24. Do you have problems associated with your menstrual period? ..... Yes No
25. Are you nursing? ..... Yes No
26. Are you taking birth control pills? ..... Yes No
27. Last menstrual period? _____

What is the main reason for your visit?

_____

_____

_____

I authorize my surgeon and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthemore, I authorize the taking of all X-Ray required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Name of Patient: _____ Sign: _____ Date: _____

Name of Parent/Guardian: _____ Sign: _____ Date: _____

Name of Doctor: _____ Sign: _____ Date: _____