Dr V Escobar
Oral Maxillofacial Surgery
Dental Implant Center

MEDICAL HISTORY

1. Who may we thank for referring you today _____
2. Are you allergic to any drugs, medication or latex? ..... ☐ YES ☐ NO
   If yes, please list _____
   _____
3. Are you now taking any drug or medication (including non-prescription and herbal)?... ☐ YES ☐ NO
   If yes, please list _____
   _____
4. Have you taken any recreational drugs within the last week?..... ☐ YES ☐ NO
5. Are you, or have you taken bisphosphonates to treat osteoporosis or loss of bone? ☐ YES ☐ NO
6. Are you or have you taken cortisone or steroids? ..... ☐ YES ☐ NO
7. Have you had any previous operation or surgery? (If yes please describe) ..... ☐ YES ☐ NO
   _____
8. Have you or a member of your immediate family had any complications with an anesthetic? .. ☐ YES ☐ NO
9. Have you have had any of the following?

YES	NO		YES	NO	
☐	☐	Hepatitis	☐	☐	Sinus Trouble
☐	☐	Anemia	☐	☐	Arthritis or Rheumatoid Disease
☐	☐	Excessive Bleeding	☐	☐	Diabetes
☐	☐	Tuberculosis	☐	☐	Epilepsy
☐	☐	Asthma	☐	☐	Stroke
☐	☐	Bronchitis	☐	☐	Psychiatric Treatment
☐	☐	Shortness of Breath	☐	☐	Immune Deficiency
☐	☐	Heart Trouble	☐	☐	Thyroid Disease
☐	☐	Heart Disease	☐	☐	Kidney Disease
☐	☐	Heart Murmur	☐	☐	Radiation Therapy
☐	☐	Swelling of Ankles	☐	☐	Venereal Disease
☐	☐	High Blood Pressure	☐	☐	TMJ Problems
☐	☐	Ulcers	☐	☐	Recent Cold

10. Do you have a disease, condition, or problem not listed above? _____

11. Do you smoke cigarettes..... ☐ YES ☐ NO Chew tobacco? ..... ☐ YES ☐ NO

12. Your Weight _____ Height _____

ADULT FEMALES

13. Are you currently pregnant or nursing? ..... ☐ YES ☐ NO

If so, how many weeks / months? _____

I have read the Notice of Privacy Practice (Signature) _____

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent or Guardian if patient is under 18 years old. Date