Great Lakes Oral and Maxillofacial Surgery, P.C.

Circle one

Mr./Mrs./Miss/Ms.:_____Name Patient Age:_____DOB:_____

Phone #:_____ Height:_____ Weight:_____

Address:_____ Soc. Sec. #____-___-_____ (for insurances)

_____

Emergency Contact name and phone #:_____

Who is your Physician? _____ Who is your Dentist? _____

What brings you to us today?(Chief Complaint):_____

Are you having pain from this?_____ If yes, how much? 1-10 _____ Past pain?_____

How is your general health?_____ Are you currently under any medical treatment? Y / N

Have you been hospitalized for any surgical procedures? Y / N

Explain:_____

Are you taking ANY medications? Y / N, List name and dose, prescription or over-the-counter (OTC) please

_____

Any blood thinners? Y / N What?_____

Any medications for osteoporosis? Y / N What?_____

Any steroids (now or in the past)? Y/N What kind?_____

Have you needed antibiotic premedication for dental treatment in the past? Y / N

Did you take antibiotics before this appointment? Y / N

Do you take any herbal supplements? Y / N

Do you use tobacco products? Y/N cigars/cigarettes/smokeless/vaping; How much?_____ Past Smoker? Y/N

Alcohol Use: Y/N; Beer___, Wine___, Liquor___; Daily___ Weekly___ Rarely____; How Much?_____

WOMEN: Are you pregnant? Y / N Are you nursing? Y / N Females: starting date of last cycle_____

Do you take Birth Control? Y / N Pills Injections Other

Explain any yes answers in this section:_____

Are you allergic to (or have you ever had an unusual reaction to:

Local anesthetics (lidocaine)	Y / N	Sulfa drugs	Y / N
Antibiotics	Y / N	Soy	Y / N
Latex or the powder in gloves	Y / N	Iodine, Betadine, Shellfish	Y / N
Aspirin or similar products	Y / N	Codeine or other opioids	Y / N
Eggs	Y / N		

Other: _____

Describe the events for any "yes" answers:_____

Do you now or have you ever had any of the following?

High Blood Pressure	Y / N	Tuberculosis (TB)	Y / N
Low Blood Pressure	Y / N	Emphysema	Y / N
Heart disease	Y / N	Asthma	Y / N
Heart surgery	Y / N	Respiratory Problems	Y / N
Cardiac Pacemaker	Y / N	Rheumatic Fever	Y / N
Heart Murmur	Y / N	Anemia	Y / N
Mitral Valve Prolapse	Y / N	Bleeding/Clotting Problems	Y / N
Angina	Y / N	Epilepsy/Convulsions	Y / N
Stroke	Y / N	Liver Disease	Y / N
Chest Pains	Y / N	Glaucoma	Y / N
Winded Easily	Y / N	Use of prescription pain pills	Y / N

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Use of recreational drugs	Y / N	Thyroid Diseases	Y / N
AIDS or HIV	Y / N	Joint Replacement	Y / N
Hepatitis	Y / N	Unexplained Weight Loss	Y / N
Stomach/Intestine Problems	Y / N	Dizziness/Fainting	Y / N
Cancer	Y / N	Psychiatric concerns	Y / N
Leukemia	Y / N	TMJ Problems	Y / N
Radiation Therapy	Y / N	Oral appliances (night guard)	Y / N
Diabetes	Y / N	Frequent Ulcers	Y / N
Kidney Diseases	Y / N	Antibiotics for dental treatment	Y / N
Sleep Apnea	Y / N	Dental Implants	Y / N
		Dentures	Y / N

Do you have any difficulty getting numb for dental procedures? Y / N

Please list any conditions not asked:_____

Explain any yes answers in the last section:_____

Additional space for listing medications or reactions: _____
_____
_____
_____

Are you apprehensive / afraid of the dentist? Yes, No, A Little, A Lot, Other:_____

Please describe any negative dental experiences you may have had in the past:
_____
_____

Preferred Pharmacy:_____

Signature:_____

Date:_____

How did you hear about us? Select all that apply.

Dentist referred _____
Print advertisement _____
Radio advertisement _____
Program at sports _____
Program at arts _____
Internet _____
Yellow Pages _____
Television Ad _____
Other _____

OFFICE USE ONLY:

Local | N20 | IV | Platinum

Other: _____

Time: _____ minutes