Great Lakes Oral and Maxillofacial Surgery, P.C.

Mr./Mrs./Miss/Ms.:________________________________ Patient Age:_______DOB:________________
Phone #:_____________________________________ Height:___________ Weight:____________
Address:_____________________________________ Soc. Sec. #____-___-_____ (for insurances)

Emergency Contact name and phone #:____

Who is your regular Physician? Name:____
Who is your regular Dentist? Name:____
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; 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	Winded Easily	Y / N
Low Blood Pressure	Y / N	Tuberculosis (TB)	Y / N
Heart disease	Y / N	Emphysema	Y / N
Heart surgery	Y / N	Asthma	Y / N
Cardiac Pacemaker	Y / N	Respiratory Problems	Y / N
Heart Murmur	Y / N	Rheumatic Fever	Y / N
Mitral Valve Prolapse	Y / N	Anemia	Y / N
Angina	Y / N	Bleeding/Clotting Problems	Y / N
Stroke	Y / N	Epilepsy/Convulsions	Y / N
Chest Pains	Y / N	Liver Disease	Y / N

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

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 _____