Maxillofacial and Facial Aesthetic Surgery, LTD
Confidential Medical History Form

Patient Introduction

Date:	Patient Name Last:	Middle:	First:

Sex:	Age:	DOB:	Physicians Name and Phone #:

Medical History

	Yes	No		Yes	No		Yes	No
Shortness of Breath			Sugar or Protein in Urine			Deafness/Impaired Hearing		
Chest or Heart Pain/ Angina			Skin/Autoimmune Problems			Radiation Therapy		
High or Low Blood Pressure			Arthritis/Joint Problems			Epilepsy or Seizure		
Heart Valve Problems/Rheumatic Fever			Chronic Diarrhea/Bowel Disease			Emotional/Psychiatric Prob.		
Heart Arrythmias/Pacemaker			Hepatitis B/C			Frequent Headaches/Migraines		
Anemia/Blood Disease/Transfusion			Jaundice/Liver Trouble			Eye problems		
Heart Disease/Heart Attack/Stents			Stomach/Duodenal Ulcers			Glaucoma		
Ankle Swelling/Perfusion Issues/DVT			Vomiting Blood/Black Stools			Contact Lenses		
Frequent Colds/Cough			Recent Gain or Loss of Weight			Eye Dryness		
Asthma/Reactive Airway Disease			Kidney Trouble or Nephritis			AIDS/HIV		
Chronic Bronchitis/Emphysema			Painful/Bloody Urination			Limited Activity (Why?)		
Excessive Bleeding/Easy Bruising			Neck/Lower Back Trouble			Artificial Joints (Where?)		
Tuberculosis (Active or Treated?)			Stroke/Aneurysm			Are you Pregnant?		
Parkinson's/Huntington's/Alzheimer's			Facial Paralysis/Numbness/ Bell's Palsy			Are You on Hormone Replacement Therapy?		
Thyroid Disease (Hyper or Hypo?)			Cancer/Tumor (Where?)			Are taking or have you taken Bisphosphonates (Fosamax, Actonel, Boniva, Aredia or Zometa)		
Diabetes (Type 1 or 2)			Dizziness/Fainting					

Oral History

	Yes	No		Yes	No		Yes	No
Removable Dental Appliance			Frequent and Recurrent Mouth Sores			Oral Cancer/Tumor		
Oral Pain			TMJ Dysfunction/Pain			Orthodontics History		
Oral Surgery History			Persistent Swollen Glands			Sinus Problems		
Smoking Use: How Long and How many Packs/Day?_____			Alcohol Use: How Much and How Often? ________________			Facial Reconstructive Surgery		

Anesthesia History

	Yes	No		Yes	No		Yes	No
Have you had any anesthetic complications?			Have you received general anesthetic in the past 6 months?			Have you, or any member of your family, ever had malignant hyperthermia?		

List Previous Hospitalizations and Anesthetic Complications	List All Medications including Vitamins/Herbs		List All Allergies to Drugs, Foods, Products	List Height	List Weight

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:______________________________

Guardian's Signature:____________________________ **Doctor's Initials:**______