Lakewood Oral & Maxillofacial Surgery Specialists

3500 NE Ralph Powell Rd. - Suite D
Lee's Summit, MO 64064

Patient Health History Form: **Today's Date:** _____

Your answers on this form will allow us to better understand your medical history and conditions. Please answer all questions completely and accurately. If you have any questions regarding answering specific items on this questionnaire, please ask one of our staff for assistance. **Thank You!**

PATIENT

Name: _____ **Date of Birth:** _____

Physician's Name:_____ **Phone Number: ( )** _____

Dentist's Name:_____ **Phone Number: ( )** _____

How did you hear about Lakewood Oral and Maxillofacial Surgery Specialists:

_____

I. Main Reason for Today's Visit: **Height** _____ **Weight** _____

_____

II. Do you currently have or have you ever had any of following:

- ☐ High Blood Pressure ☐ COPD
- ☐ Asthma ☐ Emphysema ☐ Bronchitis
- ☐ Other Pulmonary Disorders: _____
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ Stomach Ulcers
- ☐ Crohn's Disease ☐ Ulcerative Colitis
- ☐ Other Stomach Disorders:_____
- ☐ Arthritis ☐ Gout
- ☐ Seizures ☐ Epilepsy
- ☐ Sleep Apnea ☐ CPAP ☐ BIPAP
- ☐ Skin Diseases/Disorders
- ☐ Glaucoma ☐ Other Eye Disorders: _____
- ☐ Thyroid/Adrenal Diseases/Disorders
- ☐ Kidney/Bladder Diseases or Transplants
- ☐ Anemia ☐ Sickle Cell Anemia
- ☐ Blood Clotting Diseases/Disorders
- ☐ Malignant Hyperthermia
- ☐ Hepatitis ☐ HIV/AIDS

III. Do you currently have or have you ever had any of the following conditions or used any of the following medications:

- ☐ Psychiatric Care
- ☐ Radiation
- ☐ Chemotherapy
- ☐ Artificial Joints
- ☐ History of Blood Clots
- ☐ Contact Lenses
- ☐ Blood Transfusions
- ☐ Lengthy Hospitalizations
- ☐ Lengthy Steroid Treatment

☐ Cardiac Conditions
- ☐ Heart Murmurs ☐ Rheumatic Fever
- ☐ Prosthetic Heart Valves
- ☐ Pacemaker
- ☐ Cardiac Stents ☐ Coronary Bypass
- ☐ Stroke ☐ Heart Attack
- ☐ Endocarditis
- ☐ Other Heart Conditions:_____

☐ Use of Blood Thinning Medications
- ☐ Aspirin How many mg's: _____
- ☐ Coumadin (Warfarin)
- ☐ Plavix (Clopidogrel)
- ☐ Lovenox (Enoxaparin)
- ☐ Pentoxifylline (Trental, Pentoxil)
- ☐ Pradaxa ☐ Aggrenox ☐ Effient
- ☐ Xarelto ☐ Eliquis ☐ Other _____

Are you currently taken or have you recently taken any immunosuppressant medications (Cortisone, Prednisone, Methotrexate, Remicade, etc.) **Yes** ☐ **No** ☐

IV. Do you have any medical issues not listed on this page: Yes ☐ **No** ☐

If yes, explain: _____

V. Women Only:

Yes or No			Yes or No		
☐	☐	Are you currently pregnant or nursing	☐	☐	Are you taking Birth Control Pills

Please circle below the osteoporosis medications that you currently take or have taken in the past.

Bisphosphonate Usage: *Reclast (IV Zoledronic Acid), Zometa (IV Zoledronate), Aredia (IV Pamidronate), Prolia/Xgeva (Denosumab), Boniva (Ibandronate), Actonel (Risedronate), Fosamax (Alendronate), Skelid (Tiludronate), Benefos (Clodronate) and Didronel (Etidronate).*

Please list the length of time you have used the above medication(s):_____

_____

VI. Allergies or Reactions to Medications:

1. _____
2. _____
3. _____
4. _____
5. _____

VII. Prescriptive and Non-Prescriptive Medications:

	Dose (mg/pill)	*How Many Times per Day*
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5 _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

VIII. Surgical History: *(Please list ALL Surgeries with Dates):*

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5._____ _____

IX. Social History:

Alcohol: ☐ Yes ☐ No _____# drinks per week and for how many years _____

Tobacco: ☐ Yes ☐ No _____# packs per day and for how many years _____

Recreational Drugs: ☐ Yes ☐ No _____

X. Family History: (Please indicate the status of any of your immediate family members):

Yes	No		Yes	No	
☐	☐	Heart Disease/Heart Attacks	☐	☐	Genetic Disorders
☐	☐	Congenital Heart Problem	☐	☐	Cancer
☐	☐	Hypertension	☐	☐	Malignant Hyperthermia
☐	☐	Stroke	☐	☐	Diabetes
☐	☐	Bleeding/Clotting Disorder			
☐	☐	Anesthesia Complications: _____			

Other: _____

To the best of my knowledge, I have answered every question completely and accurately. I authorize Lakewood Oral and Maxillofacial Surgery Specialists to furnish information to insurance companies as needed. I authorize payment from insurance company or companies to go directly to this office. I understand that I am financially responsible for charges for my treatment. I consent to the performing of advised and necessary procedures for diagnosis and treatment.

Patient (parent/legal guardian) Signature:_____ Date:_____

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