North York
ORAL & MAXILLOFACIAL SURGERY CENTRE

Medical History

Name____**Date**:________________________

Have you been under the care of, or examined by a physician recently?
Yes ☐ No ☐

Are you currently or within the last year taking any medicines or drugs?
Yes ☐ No ☐
If yes, please list on next page.

Are you currently taking any vitamins or herbal supplements?
Yes ☐ No ☐
If yes, please list on next page.

Do you have any allergies?
Yes ☐ No ☐
If yes, please list on next page.

Have you ever been warned against taking any specific types of medication?
Yes ☐ No ☐

Have you or a blood relative of yours ever had an unpleasant experience with drug or anesthetic?
Yes ☐ No ☐

Has your energy level, weight or appetite changed dramatically recently?
Yes ☐ No ☐

Do you follow a special diet?
Yes ☐ No ☐

Are you pregnant?
Yes ☐ No ☐

Do you bleed more than 10 minutes from a cut?
Yes ☐ No ☐

Do you have any restricted movement of your neck?
Yes ☐ No ☐

Have you ever fainted?
Yes ☐ No ☐

Do you ever get fluttering or pounding feeling in your chest?
Yes ☐ No ☐

Do you have chest pain on exertion?
Yes ☐ No ☐

Do your ankles, feet or hands swell?
Yes ☐ No ☐

Do you get short of breath after climbing two flights if stairs?
Yes ☐ No ☐

Do you have difficulty breathing through your nose?
Yes ☐ No ☐

Are you thirsty much of the time or do you urinate more than 6 times daily?
Yes ☐ No ☐

Do you find yourself hot or cold when others around are comfortable?
Yes ☐ No ☐

Have you ever had an illness that resulted in a long absence from school or work?
Yes ☐ No ☐

Have you ever been in the hospital overnight?
Yes ☐ No ☐

Have you ever had an operation?
Yes ☐ No ☐

Do you currently or have you ever smoked?
Yes ☐ No ☐
If yes, how many:

Do you drink alcohol?
Yes ☐ No ☐
If yes, how much:

Do any diseases seem to run in your family?
Yes ☐ No ☐
If yes, please list on next page.

Do you wear contact lenses?
Yes ☐ No ☐

Have you ever had any of the following?

- ☐ Asthma
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Arthritis/ Gout
- ☐ AIDS/ HIV
- ☐ Bronchitis
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Cortisone/ Steroid
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy/ Seizures
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Rhythm Disorder
- ☐ Heart Pacemaker
- ☐ Hepatitis B / C
- ☐ Hypertension
- ☐ Jaundice
- ☐ Lung Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Malignant Hyperthermia
- ☐ Pneumonia
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Venereal Disease

Current Medications, Allergies and Notes

Medications:

Allergies:

Notes/Misc:

Medical History Update

	Date:	Date:	Date:	Date:
Have there been any changes in your medical history?				
Have you had any serious illnesses?				
Are you taking any new medication?				
Are you under the care of a physician?				
Women: Are you pregnant?				

I understand the preceding questions and I have answered them truthfully and completely.

Signature ______________________________