



# MAXILLO FACIAL & ORAL SURGEON

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FULL NAME & SURNAME: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_

TEL: \_\_\_\_\_

**MEDICAL HISTORY :** To your knowledge, do you, or have you ever had any of the following (Tick Y/N):

*It is vital that you disclose any and all medical conditions that you may have, as failure to disclose may result in adverse outcomes associated with any possible treatment you may need*

	Y	N		Y	N		Y	N
Recent cold			Chest tightness (angina			Back problems		
Cough or lung problem			Heart murmur			Vision problems		
Asthma, wheezing			Heart attack			Hearing problems		
Shortness of breath			Rheumatic fever			Liver disease, jaundice		
Stomach ulcer			Chronic heartburn			Kidney disorders		
Thyroid disorder			High blood pressure			Diabetes		
Sleep disorders			Stroke			Blood transfusions		
Multiple sclerosis			Anaemia			Hepatitis		
Epilepsy			Blood clots			Tuberculosis		
Skin problems			Bleeding or bruising			HIV/AIDS/STD's		
Prosthetic heart valve			Prosthetic joint					

Any other medical complaints: \_\_\_\_\_

**Allergies [if any]:** \_\_\_\_\_

Previous hospitalisations [if any]: \_\_\_\_\_

If any prostheses, Date of implantation: \_\_\_\_\_

Do you smoke? Yes  No

Are you pregnant? Not applicable  Yes  No

List any medication or drugs that you are currently on:

\_\_\_\_\_  
\_\_\_\_\_