ROANOKE ORAL SURGERY, INC.

PRACTICE LIMITED TO ORAL & MAXILLOFACIAL SURGERY

ROANOKE ORAL SURGERY, INC.
6035 PETERS CREEK ROAD
ROANOKE, VA 24019
(540) 362-5900

MEDICAL INFORMATION

PATIENT FULL NAME: ______________________________ **DATE OF BIRTH:** ____________________

What complaint brought you to this office? ______________________________

Give Details : ______________________________

PLEASE CHECK THE APPROPRIATE BOX IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

☐ AIDS (HIV Infection)
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Disease
☐ Cancer
☐ Chest Pain (Angina)
☐ Diabetes
☐ Emphysema
☐ Glaucoma
☐ Heart Disease (or Heart Attack)
☐ Heart Murmur
☐ Herpes
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease (Cirrhosis or Hepatitis)
☐ Low Blood Pressure
☐ Lung Disease
☐ Malignant Hyperthermia
☐ Nervous Disorder
☐ Rheumatic Fever
☐ Seizure Disorder
☐ Shortness of Breath
☐ Sickle Cell Disease or Trait
☐ Sleep Apnea/CPAP
☐ Stomach or Intestinal Disorder
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Venereal Disease

PLEASE CHECK YES OR NO TO THE FOLLOWING QUESTIONS AND EXPLAIN:

Question	YES	NO
Are you allergic to any medication or materials such as latex? If yes, please list: ______________________________	☐	☐
Do you use biphosphonates such as Fosamax, Actonel, etc. ? (These drugs are generally employed orally for osteoporosis and sometimes intravenously for malignancy).	☐	☐
Have you taken or are you taking steroids (cortisone, prednisone)?	☐	☐
Are you taking any anticoagulants (blood thinners)? Please list: ____________________	☐	☐
Are you presently under the care of a physician, including pain management? Physician's Name: __________ Why? ______________________________	☐	☐
Are you taking any medications or drugs? Please list names & dosages of each drug: ______________________________	☐	☐
Do you have any abnormal growths in your mouth? Present how long? ____________________	☐	☐
Do you smoke cigarettes/cigars? If yes, for how many years? ______ How many cigarettes/cigars used a day? ____________________	☐	☐
Do you use smokeless tobacco or chewing tobacco?	☐	☐
Have you had any major surgery or serious illness? Please list and provide dates: ______________________________	☐	☐
Are you pregnant? If so, how many months? ______ Physician: ____________________	☐	☐
Are you now or have you been under psychiatric care?	☐	☐
Have you ever received therapeutic radiation for the treatment of a head/neck tumor?	☐	☐
Have you or any member of your family ever had a complication from a local or general anesthetic?	☐	☐
Do you wear contact lenses?	☐	☐
Do you now or have you ever used alcohol or other drugs in excess?	☐	☐

BY SIGNING BELOW, I ACKNOWLEDGE THAT THE MEDICAL INFORMATION I HAVE PROVIDED IS ACCURATE AND COMPLETE.

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DATE   SIGNATURE OF PATIENT OR LEGAL GUARDIAN   RELATIONSHIP TO PATIENT IF MINOR