ATKINSON ORAL SURGERY

# MEDICAL HISTORY FORM

**PATIENT NAME**: _____ **DATE OF BIRTH:**_____

*Please fill out the following questions to the best of your ability. All answers may potentially impact your clinical presentation, the treatment provided, drugs administered or prescribed, or information needed in case of an emergency. All answers are strictly MEDICAL-IN-CONFIDENCE.*

***How tall are you?*** _____***cm*** ***How much do you weigh?*** _____***kg***

## MEDICAL CONDITIONS:

Please **tick** the appropriate conditions (present or past history of the disease):

***Cardiac conditions***
1. Blood pressure: Hypertension (high) _____Hypotension (low) _____
2. Ischaemic heart disease: Myocardial infarction (heart attack) _____or Pectoralis Angina (chest pain) _____
3. Rhythm disturbances: Irregular heartbeat _____Atrial fibrillation _____Heart murmur _____
4. Infective endocarditis _____or rheumatic heart fever _____
5. Cardiac surgery: Stents_____Bypass surgery_____Valve replacement _____
6. Other/Comments: _____.

***Respiratory conditions***
1. Asthma _____Triggers: _____.
2. Bronchitis _____Emphysema _____ Pneumonia _____
3. Other/Comments: _____.

***Gastrointestinal conditions***
1. Gastro-oesophogeal reflux disorder _____Gastritis _____Ulceration _____
2. Irritable bowel syndrome/disease (IBS/D) _____Crohn's disease_____Coeliac disease _____
3. Other/Comments: _____.

***Hepatic disease***
1. Fatty liver_____Liver failure_____Viral hepatitis infection (e.g. Hep A, B, C) _____
2. Other/Comments: _____.

***Renal disease***
1. Kidney failure _____Dialysis_____
2. Other/Comments: _____.

***Endocrine***
1. Diabetes mellitus: Type I _____Type II _____Gestational_____ BSL measured today? _____Value_____*mmol/L*
2. Thyroid_____ Parathyroid_____ Adrenal_____
3. Other/Comments: _____.

***Infectious Diseases***
1. Human immunodeficiency virus (HIV) _____Tuberculosis (TB) _____ 'Golden Staph'_____
2. Chlamydia _____Genital herpes (oral or genital) _____Papilloma virus (warts) _____
3. Other/Comments: _____.

***Tumour/Growth/Malignancy***
1. Cancer: _____.
2. Other/Comments: _____.

***Autoimmune***
1. Rheumatoid arthritis _____Sjogren's Syndrome _____
2. Other/Comments: _____.

***Neurological***
1. Depression _____Anxiety _____Epilepsy _____History of seizures _____
3. Other/Comments: _____.

***Cerebrovascular/Haematological***
1. Stroke _____
2. Headaches _____Migraines _____Anaemia_____
3. Haemophilia _____Von Willebrand's disease _____
4. Other/Comments: _____.

***Musculoskeletal***
1. Osteoarthritis_____ Osteoporosis_____ Joint replacement/prosthetic joint_____
2. Other/Comments: _____.

***Skin disease:***_____.

***Eye disease***:_____.

***Is there any medical condition that runs in the family?*** _____.

***What is the maximum you can walk without stopping or being out of breath?***
*Flights of stairs: >2*_____*2*_____*1*_____*half a flight*_____*around the house*_____

**VACCINATION STATUS:**
1. Are you aware of any outstanding vaccinations that you require? _____.
2. Other/Comments: _____.

**MEDICATIONS:**
Please list all medications you are taking (including any over-the-counter, prescribed and self prescribed, or herbal remedies) and dosage:

| | *Drug name* | *Amount* | *Frequency* |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

11. Do you take any drugs for your bones? _____.
12. Do you take any blood thinning drugs e.g. aspirin, warfarin? _____.
13. Do you take any drugs that suppress your immune system e.g. prednisone? _____.

**ALLERGIES:**
1. What drugs or substances, including foods, are you allergic to? _____
_____
_____

*Note*: an allergic reaction can include symptoms such as rash, swelling, shortness of breath, vomiting, nausea after being exposed. It can have an immediate or delayed onset.

**SMOKING STATUS:**
1. Please circle: *never smoked* or *past/present* smoker.
2. Approximate number of years as a smoker: _____*years*. Approximate number of cigarettes per day: _____*cigs/day*.
3. Any other forms of tobacco e.g. snuff, areca nut, pipes, cigars? _____

**RECREATIONAL DRUG USE:**
1. Do you take any recreational drugs (e.g. marijuana, methamphetamines, opioids)? _____

**DRINKING HABITS:**
1. Average amount of water consumed _____*L/day.*
2. Average number of alcoholic drinks per week _____

**FEMALES:**
1. Is there any chance of you being pregnant? _____
2. If yes to question 1, how many weeks? _____
3. Are you currently breastfeeding? _____
4. Are you currently on the contraceptive pill? _____

**ORAL HYGIENE HABITS:**
1. How many times a day do you brush your teeth? _____
2. How many times a week do you clean between you teeth (e.g. floss, interproximal brushes)? _____
3. What type of toothpaste do you use? _____.
4. Do you use any mouth rinses? _____What type? _____How often?_ _____.

**GP DETAILS:**

NAME_____PRACTICE_____

PHONE NUMBER_____

**OTHER HEALTH SPECIALISTS:**

NAME_____PRACTICE_____

PHONE NUMBER_____

NAME_____PRACTICE_____

PHONE NUMBER_____

**PREVIOUS OPERATIONS:**

| *Year* | *Operation* | *Hospital* |
|---|---|---|
| | | |
| | | |
| | | |

**OTHER COMMENTS:**
_____
_____
_____
_____
_____

*PATIENT/GUARDIAN'S SIGNATURE:* _____ *DATE:* _____

*DR MARK DANIEL ATKINSON:* _____*DATE:* _____

*Thank you for filling this medical history form out. If you have any questions or need clarification on anything, please discuss with you clinician.*