BOULDER VALLEY
ORAL & MAXILLOFACIAL SURGERY

Patient Name _____ Birthdate_____

Address _____ City_____ State_____ Zip_____

Phone # _____ Email _____

Emergency Contact/Relation _____ Phone # _____

Pharmacy/Location_____Referred by:_____

What medical conditions have you been diagnosed with?
(1)_____ (2)_____
(3)_____ (4)_____
(5)_____ (6)_____

Please list all medications taken (prescription, supplements, vitamins, over-the-counter medications, etc.).
(1)_____ (2)_____
(3)_____ (4)_____
(5)_____ (6)_____
(7)_____ (8)_____

Do you have any allergies or adverse reactions to medications, products, or food?
(1)_____ (2)_____
(3)_____ (4)_____
(5)_____ (6)_____

What surgeries have you had in the past? Include any procedures in which you were given sedation.
(1)_____ (2)_____
(3)_____ (4)_____
(5)_____ (6)_____

Have you had any complications with anesthesia in the past? If so, what was the complication that occurred?
_____
_____

Are you aware if anyone in your family had issues with the anesthesia in the past?
_____
_____

How many alcoholic beverages do consume during the week (on average)?
_____

If you smoke, how many cigarettes do you smoke per day and for how many years?
_____

Do you engage in any other drug use? _____

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Do any medical conditions run in your family (hypertension, diabetes, etc.)? _____

Have you ever been to the emergency room or admitted to the hospital in the past? What for and during which year(s)? _____

Have you ever been on medication for osteoporosis or any type of cancer? Please list names and the dates taken. _____

Please list the names of current treating physicians: _____

Is there anything else that you would like the doctor to know? _____

Are you pregnant or breast feeding? _____

Please circle Yes or No to the following questions. Do you have, or have you had:

Rheumatic heart fever/disease	Y / N	Hepatitis or liver disease	Y / N
Congenital heart lesions	Y / N	Stomach ulcers	Y / N
Heart attack, stroke, hypertension	Y / N	Gastric reflux	Y / N
Seasonal/Environmental allergies	Y / N	Arthritis	Y / N
Asthma	Y / N	Renal or kidney disease	Y / N
Chronic sinus congestion	Y / N	Seizures	Y / N
Psychiatric disorders (anxiety, etc.)	Y / N	Glaucoma	Y / N
Fainting spells	Y / N	Bleeding disorders	Y / N
Diabetes	Y / N	Cold sores	Y / N

_____

_____

_____ _____

Signature of Patient or Legal Guardian Date