Oral Surgery Associates of Central Georgia - Medical Form

Have you had or currently have…	Yes	No	Notes	Have you had or currently have…	Yes	No	Notes
Rheumatic fever?				Low blood sugar?			
Damaged heart valves / Mitral valve prolapse?				Swollen ankles, arthritis or joint disease?			
High blood pressure?				Kidney trouble?			
Low blood pressure?				Stomach ulcers?			
Chest pain, angina?				Contagious disease?			
Heart attack(s)?				AIDS or HIV carrier?			
Irregular heart beat?				A tumor or growth?			
Cardiac pacemaker?				Radiation treatment / Chemotherapy?			
Heart surgery?				Chronic fatigue / Night sweats?			
Bronchitis, chronic cough?				Sexually transmitted diseases?			
Asthma?				Are you pregnant or nursing?			
Hay fever?				A history of drug abuse?			
Sinus problems?				A history of alcohol abuse?			
Tuberculosis (TB)?				Contact lenses?			
Emphysema?				Eye disease / glaucoma?			
Difficulty breathing or other lung trouble?				Problems with the immune system?			
Do you smoke?				Mental health problems?			
Blood transfusion?				Removable dental appliance?			
Blood disorder / anemia?				Pain and/or clicking of jaws?			
Bruise easily?				Malignant hyperthermia or complications with anesthesia?			
Excessive bleeding tendencies?				Jaundice, hepatitis or liver disease?			
Seizures, epilepsy?				Diabetes?			
Infectious mononucleosis?				Thyroid trouble?			
Gallbladder trouble?				Stroke?			

- Please list any condition for which you are under a physician's care:

  _____

- Are you taking or have you ever taken bisphosphonates (Fosamax, Actonel, Boniva, or Reclast), for osteoporosis, chemotherapy (Aredia or Zometa) or for multiple myeloma or other cancers?

  Yes_____ No _____

- Please list any medications you are currently taking:

  _____

- Please list any surgeries or serious illnesses:

  _____

- Please list any drug allergies:

  _____

- Who referred you to our office:_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Szakal, or and his staff, responsible for any errors or omissions that I have made in the completion of this form. I authorize Dr. Szakal and his staff to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays, which must remain the property of Dr. Szakal, required as a necessary part of this examination.

X_____ X_____

Signature of Patient (Parent or Guardian if minor) Date