The Center for Jaw and Facial Surgery, P.C.
Jay I. Swanson, D.D.S., M.D.
Oral & Maxillofacial Surgeon

Medical History - Confidential

Today's Date: _____

PATIENT NAME_____ **Date of Birth:** _____

DENTAL HISTORY

Reason for today's visit:_____

DENTIST NAME _____**Date of last dental x-rays**_____

MEDICAL HISTORY

PHYSICAN'S NAME_____Date of last visit_____

Have you had any serious illnesses or operations?_____ If yes, describe _____
_____

Have you ever had a blood transfusion? ? □ YES □ NO If yes, give approximate date:_____

(Women) Are you pregnant? □ YES □ NO Nursing? □ YES □ NO Taking birth control pills? □ YES □ NO

Check (X) if you have or ever have had problem with any of the following: □ LAST 6 MONTHS □ EVER

□ □ Anemia	□ □ Cortisone Treatments	□ □ Hepatitis	□ □ Scarlet Fever
□ □ Arthritis, Rheumatism	□ □ Cough, Persistent	□ □ High Blood Pressure	□ □ Shortness of Breath
□ □ Artificial Heart Valves	□ □ Cough up Blood	□ □ HIV/AIDS	□ □ Skin Rash
□ □ Artificial Joints	□ □ Diabetes	□ □ Jaw Pain	□ □ Stroke
□ □ Asthma	□ □ Epilepsy	□ □ Kidney Disease	□ □ Steroid treatments
□ □ Back Problems	□ □ Fainting	□ □ Liver Disease	□ □ Thyroid Problems
□ □ Blood Disease	□ □ Glaucoma	□ □ Mitral Valve Prolapse	□ □ Tuberculosis
□ □ Cancer	□ □ Headaches	□ □ Pacemaker	□ □ Other
□ □ Chemical Dependency	□ □ Heart Murmur	□ □ Radiation Treatment	□ □
□ □ Chemotherapy	□ □ Heart Problems	□ □ Respiratory Disease	□ □
□ □ Circulatory Problems	□ □ Hemophilia	□ □ Rheumatic Fever	

Do you smoke, vape or chew tobacco? How much?_____
Do you use alcohol or marijuana ? How much/often?_____

MEDICATIONS

Are currently taking any medications? YES NO

If so please list on back_____

_____
Pharmacy Name:_____
Phone #:_____

ALLERGIES

□ Aspirin □ Penicillin
□ Barbiturates (sleeping pills) □ Sulfa
□ Codeine □ Latex
□ Local Anesthetic □ Other

□ No Known Allergies

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member o his/her staff responsible for any errors or omissions that I have made in the completion of this form.

SIGNATURE:_____ DATE _____

Doctor Signature:_____ DATE _____

The completed form may be faxed to 217-347-8928