Anthony J. Hornaday, D.D.S.
Oral and Maxillofacial Surgery

Medical History

Patient Name: ____
First Middle Last Nickname

Reason for today's office visit: ____

Height: __________ Weight: ___________ Age: __________

	Yes	No	Notes
Have there been any changes in your general health in the past year?..............................>	☐	☐	
Are you under the care of a physician?..............................> For what? ____________	☐	☐	
Have you ever been hospitalized or undergone any surgery?..............................> Please explain: ____________	☐	☐	

Please indicate if you have ever had any of the following conditions:

	Yes	No	Notes		Yes	No	Notes
Heart Disease				Anemia			
Chest Pain				Bleeding Problems			
Heart Attack				Sickle Cell Anemia			
Bypass				Stomach Ulcer			
Angioplasty				HIV or AIDS			
Heart Murmur				Cancer or Tumors			
Mitral Valve Prolapse				Radiation/Chemotherapy			
Rheumatic Fever				Liver Disease			
High Blood Pressure				Hepatitis or Jaundice			
Artificial Heart Valve				Diabetes			
Pacemaker				Thyroid Disease			
Stroke				Kidney Disease			
Glaucoma				Arthritis			
Asthma				Artificial Joints			
Lung Disease				Seizures (epilepsy)			
Tuberculosis				Elicit (Illegal) Drug Use			
Shortness of Breath				Alcohol/Drug Abuse			
Swollen Ankles				Psychiatric Disorder			

	Yes	No
• Are you currently taking any drugs or medications?..............................> Please List: ____________	☐	☐
• Have you ever had any adverse reaction to local or general anesthetic?..............................>	☐	☐
• Are you allergic to anything?..............................> Please List: ____________	☐	☐
• Have you ever been treated or are you taking medicine for osteoporosis?..............................>	☐	☐
• Have you ever been prescribed any of the following medications: Fosamax, Aredia, Zometa, Actonel, Boniva?..............................>	☐	☐
• Is this visit a result of an accident?..............................> If yes, date of accident and describe: ____________	☐	☐
• Do you smoke?..............................>	☐	☐
• Women: Are you pregnant?..............................>	☐	☐
Are you nursing?..............................>	☐	☐
Do you take birth control?..............................>	☐	☐
• Do you have any other medical conditions not listed above?..............................> Please List: ____________	☐	☐

I certify that I have read and understand the above and that the information is correct and accurate. I will not hold Dr. Hornaday or members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signed: ______________________________ ______________________ Date: ____________
Patient or Legal Guardian Signature Relationship to Patient

Print Name: ____

The following several paragraphs pertain to all Oral and Maxillofacial Surgery procedures.

I realize the importance of supplying true and accurate information about my health, especially concerning possible pregnancy, allergies, medications, and history of drug or alcohol abuse. I understand that if I misinform my doctor the consequences may be life threatening or otherwise adversely affect the results of my surgery.

While performing my surgery I recognize that Dr. Hornaday may discover other or different conditions than expected. This may require different or additional procedures than those planned or may require termination of my surgery. I authorize Dr. Hornaday to perform such other procedures as he deems medically and/or surgically necessary in his professional judgment or to stop my procedure.

I consent to the administration of anesthetics and medications as may be deemed necessary or advisable for my comfort, health, and safety. If general anesthesia is used, I understand that there may be soreness, redness, swelling, and/or bruising at or around the IV site or along the vein that may require additional treatment. Other rare complications of IV anesthesia may include allergic reaction to medications, respiratory problems that may require a breathing tube be placed, stroke, heart attack, heart failure, and/or death.

I am also aware that oral sedation, intravenous (IV) sedation, general anesthesia, and many drugs are not recommended for use for women who are pregnant. I understand that it is my responsibility (or the responsibility of a parent or legal guardian of a female patient) to advise Dr. Hornaday if I am pregnant or possibly could be pregnant.

I also have been informed by Dr. Hornaday that antibiotics *can* and *may* interfere with the effectiveness of birth control and that I *can* and *may* become pregnant if another form of contraception is not used. I also understand and have been informed that if antibiotics are used in my care I will need to use another form of contraception and should consult my medical doctor.

I have been made aware that certain medications, drugs, anesthetics and prescriptions that I may be given can cause drowsiness, and lack of awareness and coordination which also may be increased by the use of alcohol and other drugs. I understand that I should not use alcohol, operate a vehicle or other hazardous machinery, or make any legal decisions while under the influence of any medication, anesthesia, or prescription given by this office. I have been advised not to return to work while taking such medications, or until fully recovered from the effects of such medications, drugs, anesthetics and/or prescriptions. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am given sedative medication for my surgery, I agree not to drive myself to the appointment or home afterwards and will have a responsible adult drive me to the appointment and home and accompany me until I am fully recovered from the effects of the sedation.

I certify that I have read and fully understand the terms and words in the above consent and /or any verbal explanations given to me by my doctor and/or his assistants, and that I give my consent voluntarily. I also certify that I am the *legal guardian* for the patient for whom I am completing this form.

Patient________________________________ Patient's Signature _________________________________ Date _______________

Parent or Legal Guardian Signature ____ Date _______________

Witnessed By ____ Date ________________