Knoxville Oral & Maxillofacial Surgery, PC

Turner P. Emery, DDS, MD
Michael D. Wooten, DDS

DATE:
CHART #
DOCTOR:

MEDICAL HISTORY

PATIENT NAME (Please Print): First MI Last	Age	Personal Dentist
Referred by:		Primary Care Physician

Please give the name, address, and phone of a person outside your household who could help us in contacting you.

Have you or relatives been treated by this office?

List reason(s) you have been referred to this office:

If Wisdom Teeth-Please List Symptoms and Date Symptoms Began:

List the surgeries that you have had:

Did you have general anesthesia? Yes ❑ No ❑

Medicines that you are presently taking (include birth control and any over the counter medicine such as aspirin, nutritional, herbal, or dietary supplement):

What medicines are you allergic to?
Penicillin Aspirin Demerol Codeine Sulfa Others?

YES	NO	Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, for osteoporosis)?
YES	NO	Do you drink alcohol?
YES	NO	Do you use drugs?
YES	NO	Family history of bleeding or anesthesia reactions?
YES	NO	Are you being treated by a physician for any illness?
YES	NO	Do you wish to talk to the doctor privately about anything special?

Is there anything regarding the appearance of your face, mouth, or teeth that you wish could be improved?

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:		
YES	NO	Rheumatic fever
YES	NO	High blood pressure
YES	NO	Stroke
YES	NO	Heart disease (heart attack, murmur, angina, valve replacements, bypass surgery
YES	NO	Lung disease (asthma, emphysema, TB, etc.)
YES	NO	Kidney disease
YES	NO	Liver disease (hepatitis, jaundice, cirrhosis)
YES	NO	Epilepsy or seizures
YES	NO	Diabetes
YES	NO	Mental illness/handicap
YES	NO	Fever blisters/Cold sores
YES	NO	TMJ (jaw joint) problems
YES	NO	Bleeding disorders
YES	NO	Have you ever had a blood transfusion?
YES	NO	Have you had hip or joint replacements?
YES	NO	Immune diseases
YES	NO	Do you smoke cigarettes, cigars, pipes or use smokeless tobacco?
YES	NO	Gastrointestinal disease (ulcers, colitis, diverticulitis)
YES	NO	Arthritis Type?
YES	NO	Ladies — are you pregnant?

If Due to Accident: Please List Accident Date; Give Brief Description of Accident and Claims Adjuster's Name, Telephone Number and Address.

I understand the information I have provided on this form is essential to determine my surgical needs and that I have answered all questions truthfully. I will report any changes in my health history as soon as possible.

Signature (Parent or Guardian) Date Dr.