UT SOUTHWESTERN MEDICAL CENTER

UNIVERSITY HOSPITALS & CLINICS

Department of Surgery
Oral and Maxillofacial Surgery

New Patient Medical Information Sheet

Pt. Name:_____
Address:_____
City State Zip
MRN: _____
DOB: _____
SSN: XXX-XX-___ ___ ___ ___ SEX:_____
DOS: _____

Date:_____ Age:_____

Occupation:_____

How were you referred to our clinic?

Physician (full name): Dr._____

Friend (name):_____ Other (please specify):_____

Medical/Dental history: In your own words, please state the reason for your visit **(chief complaint)**:

_____

_____

Are you in pain? ◯ No ◯ Yes

How long have you had this problem? **(duration)**_____

What parts of your teeth/mouth/head/neck are affected? **(location)**_____

What makes it better? What makes it worse? **(change in severity)**_____

_____

How does this problem bother you? **(symptoms)**_____

What treatments have you received for this problem? **(previous therapy)**_____

_____

_____

Is your problem ◯ worsening? ◯ stable? ◯ improving? **(timing)** Explain:_____

_____

Past medical/family/social history: Please list all past major illnesses and operations:

1._____ 2._____ 3._____ 4._____ 5._____

Please list <u>all medications</u> you are currently taking: 1._____ 2._____

3._____ 4._____ 5._____ 6._____

7._____ 8._____ 9._____ 10._____

Please list <u>all medication and environmental allergies</u>: ◯ Latex ◯ Nitrous Oxide

◯ Other_____

Is there a family history of a condition similar to yours? ◯ No ◯ Yes Additional information:_____

_____

Family history of (please mark the circle(s) that apply): ◯ TMJ ◯ oral cancers ◯ mouth sores

◯ genetic diseases ◯ Additional information:_____

Do you smoke or use any other form of tobacco? ◯ No ◯ Yes

If yes, how much per day?_____ For how long?_____

Do you drink alcohol? ◯ No ◯ Yes If yes, how much per week?_____

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DOS: _____

For New Orthodontic Patients Only:

1. Have you ever been evaluated or treated for orthodontic treatment before? ◯ No ◯ Yes
   If yes, Date: _____ Orthodontist:_____
2. Have there ever been any prior injuries to teeth, jaws or face? ◯ No ◯ Yes
3. Have there ever been problems with TMJ/jaw popping? ◯ No ◯ Yes
4. Are there any on-going oral habits (thumb, finger-sucking)? ◯ No ◯ Yes
5. Has puberty begun? ◯ No ◯ Yes Do you like your smile? ◯ No ◯ Yes

Women: Are you pregnant? ◯ No ◯ Yes Do you plan to become pregnant soon? ◯ No ◯ Yes
Are you nursing? ◯ No ◯ Yes

Mark circle next to any symptom or condition you are having or have had in the past.

General
- ◯ high blood pressure
- ◯ weight loss
- ◯ fatigue

Head, Eyes, Ears, Nose, Throat
- ◯ fever blisters
- ◯ dry eyes
- ◯ sinus trouble
- ◯ swallowing difficulties
- ◯ dry mouth
- ◯ sore mouth
- ◯ mouth ulcers
- ◯ cosmetic surgery

Cardiovascular
- ◯ pacemaker
- ◯ heart disease
- ◯ mitral valve prolapse
- ◯ hypertension
- ◯ chest pain/angina
- ◯ heart murmur
- ◯ rheumatic fever
- ◯ heart attack

Respiratory
- ◯ asthma
- ◯ difficulty breathing/shortness of breath
- ◯ lung disease
- ◯ emphysema
- ◯ tuberculosis
- ◯ COPD
- ◯ coughing up blood
- ◯ bronchitis

Genitourinary
- ◯ kidney disease
- ◯ sexually transmitted diseases (syphilis, gonorrhea, etc.)

Gastrointestinal
- ◯ liver disease
- ◯ ulcers

Musculoskeletal
- ◯ joint aches
- ◯ artificial joints
- ◯ arthritis
- ◯ rheumatoid arthritis

Endocrine
- ◯ diabetes
- ◯ thyroid disease/disorder

Hematologic/Lymphatic
- ◯ anemia
- ◯ bleeding problems
- ◯ sickle cell anemia
- ◯ bruise easily
- ◯ leukemia

Medications
- ◯ Phen-Fen
- ◯ Redux
- ◯ cortisone medications
- ◯ chemotherapy
- ◯ radiation therapy
- ◯ Fosamax
- ◯ Zometa

Neurologic
- ◯ epilepsy/seizures
- ◯ headaches
- ◯ stroke
- ◯ central nervous system disorders
- ◯ numbness

Psychiatric
- ◯ depression
- ◯ drug/alcohol addiction

Immunologic
- ◯ immune deficiency
- ◯ hepatitis
- ◯ HIV / AIDS

If needed, please elaborate on any of the above:_____

Thank you very much for your cooperation!

_____
Signature of Patient/Legal Representative

*Proof of status as legal representative may be required.

I have read and reviewed this form with the patient.
Physician's signature_____

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