Oral Maxillofacial Surgeons, Ltd
Martin T. Elson, DDS
1265 Reservoir Avenue
Cranston, RI 02920
(401) 464-6406

Marital Status
Name:_____Sex: M F DOB:____/____/____ Age:____ M S D W
Address:_____City, State, ZIP_____
Home#_____Cell#_____Work#_____

Medical History

Ankle swelling	YES	NO
Arthritis	YES	NO
Asthma	YES	NO
Blood transfusion	YES	NO
Bronchitis	YES	NO
Bruise easily	YES	NO
Chronic cough	YES	NO
Dizziness	YES	NO
Emphysema	YES	NO
Epilepsy	YES	NO
Excessive bleeding	YES	NO
Fainting spells	YES	NO
Family member with melanoma	YES	NO
Frequent headaches	YES	NO
Frequent indigestion	YES	NO
Frequent nose bleeds	YES	NO
Gall bladder disease	YES	NO
Hair or nail problems	YES	NO
Hay fever	YES	NO
High blood pressure	YES	NO
Head injuries	YES	NO
Heart disorder	YES	NO
Hepatitis A B C	YES	NO
Low blood pressure	YES	NO
Palpitations	YES	NO
Pneumonia	YES	NO
Psoriasis	YES	NO
Radiation therapy	YES	NO
Recent gain/loss or weight	YES	NO
Rheumatic fever	YES	NO
Shortness of breath	YES	NO
Scarlet Fever	YES	NO
Smoke	YES	NO
Soaking night sweats	YES	NO
Thyroid disease	YES	NO
Treatment for cancer	YES	NO
Tuberculosis	YES	NO
Wear sunscreen daily	YES	NO
Wear contact lenses	YES	NO
Yellow jaundice	YES	NO

Are you Pregnant? YES NO

Do you need to premedicate with antibiotics before having work done in your mouth? YES NO

Do you or anyone in your family have hemophilia? YES NO

Specify any medical problems you have had, or presently have, that are not listed on this form:_____
_____
_____
_____

List all operations you have had:_____
_____
_____
_____
_____

List all drugs/medications you are presently taking:_____
_____
_____
_____
_____
_____

List all drugs/medications to which you are allergic:_____
_____
_____
_____

When was your last physical examination?_____
Physician?_____

Have you had general anesthesia (been to sleep) in the past year? YES NOIf YES please explain_____

Dental Insurance:_____
Subscriber Name:_____
DOB:_____ID#_____

Medical Insurance:_____
Subscriber Name:_____
DOB:_____ID#_____