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?_____

Form # SYR/NPMIS-001 / 07.05

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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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