

**Excellence in Oral & Maxillofacial Surgery, LLC**  
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**PATIENT HEALTH HISTORY**

(Your responses are for our records only and will be considered strictly confidential)

Name: \_\_\_\_\_ Weight \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Yes No  
 \_\_\_\_\_ Are you presently under a physicians care? If yes, please explain: \_\_\_\_\_

Physician: \_\_\_\_\_ Dentist: \_\_\_\_\_ Orthodontist: \_\_\_\_\_

**ALLERGIES**

Yes	No		Yes	No	
_____	_____	Local Anesthetics.....	_____	_____	Codeine/ narcotics.....
_____	_____	General Anesthetics.....	_____	_____	Penicillin(s) .....
_____	_____	Aspirin .....	_____	_____	Sulfa Drugs .....
_____	_____	Soy, Eggs, Milk, Peanuts.....	_____	_____	Others (please list).....

**MEDICATIONS**

Please list any and all medications that you are presently taking (such as antibiotics, pain medication, heart medicine, anti-coagulates, etc.): \_\_\_\_\_

**DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

Yes	No		Yes	No	
_____	_____	High blood pressure .....	_____	_____	Tumor or growth.....
_____	_____	Chest pain or angina.....	_____	_____	Chemotherapy or radiation therapy.....
_____	_____	Heart attack, heart disease .....	_____	_____	Seizures, epilepsy.....
_____	_____	Damaged heart valve(s) murmur, or... Mitral valve prolapse (MVP).....	_____	_____	Mental Health Problems .....
_____	_____	Shortness of breath.....	_____	_____	Alcohol/ Drug abuse .....
_____	_____	Cardiac pace maker .....	_____	_____	Arthritis .....
_____	_____	Stroke .....	_____	_____	Jaw joint problems .....
_____	_____	Sinusitis, seasonal allergy.....	_____	_____	Osteoporosis.....
_____	_____	Asthma .....	_____	_____	Diabetes.....
_____	_____	Emphysema.....	_____	_____	Thyroid problems.....
_____	_____	Tuberculosis .....	_____	_____	Anemia.....
_____	_____	Do you smoke? Packs per day.....	_____	_____	Sickle cell trait/ disease .....
_____	_____	Smokeless tobacco? Yrs.....	_____	_____	Bruise Easily.....
_____	_____	Stomach ulcers .....	_____	_____	Abnormal or prolonged bleeding.....
_____	_____	Kidney problems.....	_____	_____	Liver Disease, hepatitis.....
_____	_____	Do you have any breathing problems?	_____	_____	HIV positive, ARC, Aids.....
_____	_____	Do you snore, or have you been told that you do? Explain _____	_____	_____	Joint Replacements.....
_____	_____	Do you have any skin problems that you would like us to address, such as acne, fine lines, skin Discoloration, etc.? _____			
_____	_____	Do you have any cosmetic concerns, such as your chin, nose, eyes, etc.?			
_____	_____	Do you have any problems chewing or eating? _____			
_____	_____	Have you ever or are you interested in a skin peel? _____			
_____	_____	Is there anything else we should know? _____			

**FEMALE PATIENTS**

_____	_____	Hormone replacement therapy.....	_____	_____	Birth control pills.....
_____	_____	Pregnant? Due Date _____	_____	_____	Nursing.....
_____	_____	Is there any other information about your health that you would like to discuss with your doctor in private?			

I hereby certify that the above information regarding the medical history of : \_\_\_\_\_ is complete, true, and correct and may be relied upon for all purposes by Excellence in Maxillofacial and Oral Surgery, their assistants, associates, and any other persons treating or assisting in the treatment of the patient.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness/Provider Signature: \_\_\_\_\_