



Oral and Maxillofacial Surgery Case Sheet

Patient Name / No: _____

Age / Gender _____

Date: _____

Junior Student Name / Number: _____

Instructor Name / Number: _____

Chief Complaint:

History of Present Complaint:

Past Dental History:

Medical History

1. Are you in good health? Yes [] No [] Blood Pressure /

2. Are you under the care of a physician? Yes [] No [] Pulse Rate

If yes, who and what is the condition being treated?

Condition _____

4. Have you ever had any serious illness or operation? Yes [] No []

If yes, what illness or operation including the date?

5. Have you ever been hospitalized? Yes [] No []

If yes, when and why?

6. Are you currently taking any drugs or medication? Yes [] No []

If yes, what Drugs and reason for use?

7. Are you sensitive or allergic to any medications? Yes [] No []

Do you or have you ever had any of the following?

Y	N	Conditions
		Abnormal Bleeding
		AIDS / HIV Positive
		Alcohol Abuse
		Allergies
		Chemotherapy
		Anemia
		Angina Pectoris
		Cancer
		Other Eating Disorder
		Arthritis
		Artificial Heart Valve
		Asthma
		Bacterial Endocarditis
		Blood Disorders

Y	N	Conditions
		Diabetes
		Latex Allergy
		Difficulty Breathing / Shortness of Breath
		Drug Abuse
		Kidney Problems/Disease/Dialysis
		Epilepsy/Seizures
		Fainting Spells
		Tumors or Growth
		Tuberculosis
		High Blood Pressure
		Hepatitis , liver disease (A/B/C)
		Heart Ailments / Heart Murmur
		Heart Surgery
		Hemophilia

Y	N	Conditions
		Xerostomia (Dry Mouth)
		Peptic Ulcers
		Stroke
		Osteoporosis or Osteopenia
		Pace Maker
		Prosthetic Joint Replacement
		Psychiatric Problems / Nervous Disorder
		Radiation Treatment
		Respiratory Disease
		Rheumatic Fever
		Thyroid or Parathyroid Disease
		Sickle Cell Anemia
		Sinus Trouble
		Stomach / Gastrointestinal Disorders

ASA

Clinical Examination:

Extraoral and Intraoral findings:

Radiographic Examination:

Provisional Diagnosis:

Procedure Done:

Instructor: _____ **Date:** _____