



<b>Modulo di Unità Operativa</b>	<b>MU 304385 18</b>  Rev. 4 del 10/02/2025 Pagina 1 di 2
<b>DAI di CHIRURGIA e ODONTOIATRIA</b> <b>UOC di CHIRURGIA MAXILLO-FACCIALE</b> <b>e ODONTOIATRIA - Borgo Roma</b>	
<b>PATIENT MEDICAL HISTORY</b>	

Surname \_\_\_\_\_ Name \_\_\_\_\_

Date of birth \_\_\_\_\_

Are you pregnant?	<b>YES</b>	<b>NO</b>
Is he a smoker? (no. of cigarettes/day.....)	<b>YES</b>	<b>NO</b>
Have you had any major hospitalizations or illnesses in the last 2 or 3 years?	<b>YES</b>	<b>NO</b>
1. Cardiac pathologies: Arrhythmias	<b>YES</b>	<b>NO</b>
Valve disease/valve replacement      When?	<b>YES</b>	<b>NO</b>
Bypass      When?	<b>YES</b>	<b>NO</b>
Heart attack      When?	<b>YES</b>	<b>NO</b>
Heart transplant      When?	<b>YES</b>	<b>NO</b>
2. Hypertension	<b>YES</b>	<b>NO</b>
3. Osteoporosis or bone diseases	<b>YES</b>	<b>NO</b>
4. Blood clotting problems	<b>YES</b>	<b>NO</b>
5. Blood diseases or immune deficiencies	<b>YES</b>	<b>NO</b>
6. Infectious diseases - Which ones?	<b>YES</b>	<b>NO</b>
7. Diabetes      Do you use insulin?	<b>YES</b>	<b>NO</b>
8. Bronchial asthma/lung disorders	<b>YES</b>	<b>NO</b>
9. Allergic reactions to:	<b>YES</b>	<b>NO</b>
10. Food intolerances to:	<b>YES</b>	<b>NO</b>
11. Liver or kidney disease	<b>YES</b>	<b>NO</b>
12. Tumor diseases (leukemia, carcinoma, others)	<b>YES</b>	<b>NO</b>
13. Epilepsy	<b>YES</b>	<b>NO</b>
14. Stroke/stroke      When?	<b>YES</b>	<b>NO</b>
15. Other		
Have you ever had any particular consequences following taking anaesthetics, antibiotics or other drugs?	<b>YES</b>	<b>NO</b>
Have you ever undergone local anesthesia?	<b>YES</b>	<b>NO</b>
<b>PHARMACOLOGICAL THERAPY</b>		
Do you need antibiotic prophylaxis before dental treatment?	<b>YES</b>	<b>NO</b>
Are you taking osteoporosis medications (bisphosphonates), which ones?	<b>YES</b>	<b>NO</b>
Medications you currently take		

Acquisition date \_\_\_\_\_

Signature \_\_\_\_\_ Doctor's signature \_\_\_\_\_

