Oral Surgery Health Questionnaire

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Patient Name_____ Birth Date_____

Age_____ Sex_____ Height_____ Weight_____

PLEASE ANSWER ALL QUESTIONS AND FILL IN BLANK SPACES. ANSWERS ARE FOR OUR RECORCORDS ONLY AND ARE CONFIDENTIAL

1	Have you had food or drinks today?	Yes	No	22	Are you **ALLERGIC/H**ave you reacted adversely to:		
2	Are you in good health?	Yes	No	a.	Penicillin, Clindamycin, other Antibiotics	Yes	No
3	Your last physical exam was on: _____			b.	Local Anesthetic (Lidocaine,Novacaine)	Yes	No
4	Are you under the care of a physician?	Yes	No	c.	Pain Pills (Norco, Percocet, Codeine, Vicodin)	Yes	No
	If so, what condition(s) are you being treated for? _____			d.	Barbiturates, Seditives, Sleeping pills	Yes	No
				e.	Asprine, NSAIDS(Motrin, Aleve, Ibuprofen)	Yes	No
	_____			f.	Eggs, Soybeans, Seafood, Shrimp, Iodine	Yes	No
				g.	Latex	Yes	No
5	Name and number of your physician._____			h.	**LIST ALL DRUG ALLERGIES**_____		
6	Have you had any serious illness or	Yes	No		_____		
	operations or have been hospitalized?	Yes	No	23	Have you had any of the following illnesses?		
	If yes, please describe and include dates. _____				**HEART**		
	_____				High Blood Pressure, High Cholesterol	Yes	No
7	Do you drink alcoholic beverages? How much? How	Yes	No		Chest pain, Angina, Heart attack	Yes	No
	often?_____				Heart Fauilure, Coronary artery disease	Yes	No
8	Do you smoke cigarettes, marijuana? How much? How	Yes	No		Heart murmur, Irregular heart beat	Yes	No
	often?_____				Heart surgery (Bypass, Stent, Vales, ect.)	Yes	No
9	Have you ever used recreational drugs? (ex. Cocain, Meth ect.)	Yes	No		Stroke, TIA's Fainting spells	Yes	No
10	Have you had abnormal bleeding or bruising	Yes	No		Rheumatic fever, Heart damage	Yes	No
	associated with previous extrations, surgeries or trama?				Family history of heart disease	Yes	No
11	Have you had a blood transfusion?	Yes	No		**LUNGS**		
12	LIST ALL MEDICATIONS, VITAMINS, AND SUPPLEMENTS				Asthma, Bronchitis	Yes	No
	_____				Emphysema, COPD	Yes	No
	_____				Lung disease, TB, Chronic coughing	Yes	No
	_____				Cough Congestion or Fever in the past 4 weeks	Yes	No
	_____				**LIVER**		
13	Are you taking **ANY** of the following?				Hepatitis, Cirrosis, Liver disease/Cancer	Yes	No
a.	Pain Medication (ex Norco, Percocet, Codeine, Vicodin, Methadone)	Yes	No		**KIDNEY**		
	Last dose?_____				Kidney disease, Dialysis	Yes	No
b.	Antibiotics. (ex Amoxicillin, Z-Pack Clindamycin)	Yes	No		**GASTROINTESTINAL**		
c.	Anticoagulants/Blood thinners? (ex. Plavix, Coumadin,	Yes	No		GERDS, Stomach ulcers	Yes	No
	Pradaxa, Xarelto, Eliquis)				Gastrointestinal disease/Cancer	Yes	No
d.	Blood pressure, Heart pills, Nitroglycerin?	Yes	No		**ENDOCRINE**		
e.	Cortisone? (Steroids)				Diabetes-Insulin or Non-insulin dependent	Yes	No
f.	Insulin, or Diabetes medications?	Yes	No		Thyroid disorders, Tumors or Cancers	Yes	No
g.	Diet pills, now or in the past? (ex. Fen-Phen, Phentramine,	Yes	No		**BLOOD**		
	Redux, Dexfenfluramine)				Anemia, Hemophilia	Yes	No
14	Have you ever taken Bisphosphonate or injectables for	Yes	No		Bleading disorders (Family History?)	Yes	No
	osteoporosis or chemotherapy? (ex. Fosamax, Actonel, Aredia,				**SKELETAL**		
	Boniva, Reclast, Zometa) For how long? Last dose?_____				Arthritis, Osteoporosis	Yes	No
	_____				Artifical joint replacement	Yes	No
15	Have you ever had radiation therapy to the head, and/or neck? Why?	Yes	No		**OTHER**		
	When?_____				Allergies,Sinus Troubles	Yes	No
16	Are you pregnant or nursing?	Yes	No		History of seizures, Epilepsy	Yes	No
17	Do you have TMJ (jaw joint) problems? (Pain, Clicking, Limits opening	Yes	No		Mental Disorders (Anxiety, Depression, ADD, ADHD	Yes	No
18	Do you have dentures, loose crowns, temps?	Yes	No		Cancer of **ANY** kind	Yes	No
19	Have you been told you need to take antibiotics before	Yes	No				
	dental treatment/ surgery? If so, why? _____				Sleep Apnea, Heavy snoring	Yes	No
20	Any adverse reactions or complications with prior dental, surgical or	Yes	No		Malignant hyperthermia (Family History)	Yes	No
	medical treatment?				HIV or AIDS	Yes	No
21	Any anesthesia complications? (Family history?)	Yes	No		T-Cell count	Yes	No
	Explain_____				Any sexually transmitted diseases	Yes	No
	_____				Autoimmune disorders	Yes	No
					Glaucoma	Yes	No
					History of organ transplants	Yes	No
					Eating disorders (Anorexia, Bulimia ect.)	Yes	No
					Other_____		

_____

Patient Signature and Date:

Doctor Signature and Date: