Health Questionnaire

___/____/____ ____ ____/____/_____

Today's Date ***Patient's Name*** ***Date of Birth***

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Name of person completing form (if different from patient) and relationship

Please answer the following questions to the best of your ability. Although Oral and Maxillofacial Surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. All information that you provide will be kept confidential.

Please answer by checking (Y) Yes or (N) No for each individual question

GENERAL INFORMATION	Y	N
Are you in good health?		
Has there been any change in your general health in the past year? If yes, explain:		
Are you currently under a physician's care? If yes, what for?		
Have you had any serious illness, operations, or hospitalization? If yes, describe:		
Have you ever had intravenous sedation or general anesthesia?		
Do you generally tolerate dental treatment well?		

Physician's Name: ________________________________Phone Number:_______________
Date of last check up with Physician: ____

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING	Y	N
Heart Disease that was detected at birth?		
Heart Murmur, Mitral Valve Prolapse, Rheumatic Fever or Rheumatic Heart Disease		
Cardiovascular Disease (chest pain, heart trouble, heart attack, coronary artery disease, palpitations, heart surgery, angioplasty, pacemaker)?		
High Blood Pressure		
Stroke		
Lung Disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)?		
Neurologic Disorder (seizure, epilepsy, fainting, dizziness, nervous disorder)?		
Blood Disease (bleeding disorder, anemia, blood transfusion, bruise easily)?		
Liver Disease (jaundice, hepatitis)?		
Kidney Disease?		
Diabetes?		
Thyroid Disease (Hypothyroidism, tumor)?		
Arthritis? If yes, which joints?		
Stomach ulcers or Intestinal problems?		
Glaucoma?		
Frequent or recurring mouth sores?		
Implants/artificial joints anywhere in your body? (heart valve, knee, hip etc…)		
Radiation (x-ray treatment for cancer) in head and neck region?		
Noises in jaw joint, pain near ear when chewing, do you grind or clench your teeth?		
Sinus or nasal problems?		
Any disease, drug or transplant operation that has depressed your immune system?		
Recurrent infections of any kind?		

ARE YOU TAKING OR USING ANY OF THE FOLLOWING:

	Y	N
Antibiotics?		
Anticoagulants (blood thinning medication)?		
Thyroid medications?		
Antihistamines, decongestants?		
High blood pressure or heart medication?		
Steroids?		
Tranquilizers, Antidepressants?		
Stomach or GI medications (antacids, etc…)?		
Cholesterol reducing drugs?		
Aspirin, Ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain relievers?		
Weight reduction pills or diet aids (this also includes over the counter or “natural” products)?		
Vitamins, Natural remedies (gingko biloba, ephedra, ginseng, etc..) or other supplements?		
Marijuana, cocaine or other “recreational” drugs?		
Any other regular medications, pills, supplements or drugs?		

Please list all current medications here:

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ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

	Y	N
Local anesthetic (Novocaine-like drugs)?		
Penicillin, Amoxicillin, Cephalosporins?		
Other antibiotics?		
Barbiturates, sedatives?		
Asprin, Ibuprofen, NSAIDS, or other pain medications?		
Codeine or other narcotics or opioids?		
Latex?		
Sulfites or Sulfiting agents used as drug or food preservatives ?		
Other allergies or reactions? If yes, list:		

ADDITIONAL INFORMATION:

	Y	N
Do you have hay fever, frequent skin rashes, etc..?		
Do you use alcohol? If yes, how often?		
Do you us tobacco in any form? If yes, how often? For how long?		
Are you, or have you been in a drug or alcohol recovery program?		
Do you have any other disease, condition or problem not listed above that you think the doctor should know about?		
Do you wish to talk to the doctor privately about anything?		
Any additional comments?		

FOR WOMEN:

	Y	N
Are you taking birth control pills? Please note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills.		
Are you pregnant, trying to become pregnant or any chance you might be pregnant?		
Are you breast feeding?		
Are you taking hormone replacement?		

I understand that information that I provide on this form is essential to determine my treatment needs and the provision of treatment. I understand that if any change occurs in my health, I will report it to the office as soon as possible. I have read and understand these questions and answered them all truthfully and to the best of my ability.

__________________________________ ________________ ____________

Signature of Patient or Responsible Party *Date* *Doctor’s Initials*