Health Questionnaire

Today's Date:____/____/_____

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Patient's Name:______________________________

How would you like to be addressed? ______________ Social Sec. #:______________ Birth Date:____/____/_____

Street Address:________________________ Apt./P.O. Box:______ City:______________ State:____ ZIP:__________

Home Phone: ________________ Cell/Text #: ________________ Work #: ____________

E-mail:______________________ How would you prefer to be contacted? ☐ Home Phone ☐Cell ☐ Text Msg

Age:______ M / F Height:______ Weight: _______ Marital Status: ____________

Place of Employment:__________________________ Occupation:________________________

Student: ☐ Full Time ☐ Part Time School: ______________________________

Dentist's Name:______________ Orthodontist:________________ Physician: ______________

Date of Last Visit to Physician:____________ Reason:______________________________

Have you ever been a patient in our office? ☐ Yes ☐ No If yes, when? ______________

Has a family member ever been a patient of our practice? ☐ Yes ☐ No If yes, when?________________

Who referred you to our office?__________________

Emergency Contact Name:________________ Relation:____________ Phone: ______________

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your body and will reflect your overall health. Problems you may have, or medications you are taking could have an important relationship with the care that we will be providing. We appreciate your taking the time to answer the questions. Your answers will be completely confidential, and only used for our records.

Reason for coming to our office today?____

Health History

	YES	NO
Have there been any changes in your health this past year? If yes, please describe:__________	☐	☐
Have you had any illness, operation, or been hospitalized in the past two years? Please describe:	☐	☐
Are you currently under the care of a physician? Please describe:__________	☐	☐
Have you ever had cancer? If yes, please list type and treatment:__________	☐	☐
Do you have any unhealed/recurrent injuries or inflamed areas, growths, or sore spots in or around your mouth? If yes, please describe where:__________	☐	☐
Have you or a close family member had any unusual or serious reactions to general anesthesia? If yes, please explain:__________	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐
Is this visit related to an accident? Please list date of accident:____/____/_____ Please describe accident:	☐	☐
Do you wish to speak to the Doctor privately about anything?	☐	☐

Women Only

☐ Are you pregnant at this time? If yes, how many months?______

☐ Are you nursing?

☐ Are you taking birth control pills?

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Health Questionnaire (cont'd.)

Health History (Continued)

Are you allergic to anything? Penicillin, Drugs, Medications, Soy, Eggs? Please list:______________________________

Have you ever had any other adverse drug reactions? Please list:______________________________

Have you ever taken cortisone or other steroid drugs?Please list:______________________________

Have you ever had radiation to your head or jaws? Please explain:______________________________

Do you currently have a fever? Please explain:______________________________

Do you currently have difficulty breathing? Please explain:______________________________

Have you travelled internationally in the last 10 days?______________________________

Have you taken the weight loss drugs Fen-Phen, Pondiminn or Redux?:______________________________

Have you used any recreational, illegal, or "street" drugs (Marijuana, cocaine, etc.) in the past 12 months?:______________

Have you ever experienced jaw joint (TMJ) pain, clicking,popping, grating, limited mouth opening or difficulty chewing?

____

Are you currently or have you in the past taken bisphosphonates? (Bone density medication: Actonel,Fosamax, Boniva, Zometa, etc.)______________________________

Please Check Yes Or No

	YES	NO	NOTES
Heart Trouble			
Heart Attack			
Chest Pain			
High Blood Pressure			
Heart Murmur			
Rheumatic Fever			
Hearing Impairment			
Sleep Apnea			
Sinus Problems			
Fainting			
Stroke			
Tuberculosis			
Kidney Condition			
Psychiatric Treatment			
Stomach Trouble			
Asthma, Emphysema			
Breathing Problems			
Hepatitis, Jaundice, Liver disease			
Glaucoma			

Please Check Yes Or No

	YES	NO	NOTES
Eating Disorders			
Porphyria			
Anemia			
Diabetes			
Epilepsy, Convulsions			
Excessive Bleeding			
Immune Deficiency			
Artifical Joint/Valve			
Prosthetic Joint/Implant			
Do you smoke?			
Please note packs per day			
How many years?			
Do you have a smoker's cough?			
Are you a former smoker?			
If yes, how many packs per day?			
How many years did you smoke?			
When did you quit?			
Do you have an Advance Directive/ DNR ("Do Not Resuscitate" Order)?			

Current Medications

Please list any Medications that you are currently taking, Dosage, and Frequency:______________________________

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Prior To Surgery

Who will drive you home after surgery? ______________________________ Relation:____________________

Do you wear contact lenses? ______________Dentures?__________

The day of surgery: Have you had anything to eat or drink in the last 6 hours?______________________________

Do you have any other information that you think we should know about?______________________________

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____

I certify that the above information is complete and accurate.

______________________________________ ______/______/______

Signature of Patient, Parent, or Guardian Date

____

Printed Name