RAYMOND L. WIGGINS, D.D.S., M.D.
Diplomate of the American Board of Oral and Maxillofacial Surgery
TEXAS ORAL AND FACIAL SURGERY, P.A.
810 South Mason Road · Suite 301 · Katy, TX 77450
Office: 281.395.1200 · Fax: 281.395.1201· www.txofs.com

HEALTH QUESTIONNAIRE

Name: ____ Social Security #:__________________________

Age:_______ Sex:________ Height:_______ Weight: ________ Date of Birth: ______/______/___________

Reason for today's visit: ____
____
____

Please circle Yes or No and explain as necessary.

1. Are you in good health? . . . . Yes No
2. Has there been any change in your health within the last year? . . . Yes No
   If yes, please explain: ____
3. Are you now under or have you ever been under the care of a physician? . . Yes No
   If yes: Physician's name: _______________________________________ Date:_____________________
   Reason: ____
   ____
4. Have you ever had any serious illness? . . . . Yes No
   If yes, please list illness and date of diagnosis and treatment: ____________________________________
   ____
   ____
5. Have you ever had surgery? . . . . Yes No
   If yes, please list the surgeries and dates: ____
   ____
   ____
6. Have you ever been hospitalized? . . . . . . Yes No
   If yes, please explain and give dates: ____
   ____
   ____
7. Do you have, or have you had ***heart, other cardiovascular problems, or chest pain***?
   a. Heart murmur or heart valve defect . . . . . Yes No
   b. Heart valve replacement . . . . . . Yes No
   c. Rheumatic fever or rheumatic heart disease . . . . Yes No
   d. Congenital heart defect or problems . . . . . Yes No
   e. Do you have a pacemaker . . . . . . Yes No
   f. Heart attack . . . . Yes No
   g. High blood pressure . . . . Yes No
   h. Low blood pressure . . . . Yes No
   i. Irregular or rapid heart beat . . . . . . Yes No
   j. Chest pain . . . . Yes No
   k. Shortness of breath . . . . Yes No
   l. CHF/ Congestive heart failure . . . . . . Yes No
   m. Swollen ankles or hands . . . . . . Yes No
   n. Artificial joints or prosthetics . . . . . . Yes No
   o. Other heart, other cardiovascular problems, or chest pain (please explain): ____________________
   ____
8. Do you have, or have you had ***lung problems***?
   a. Asthma . . . . Yes No
   b. Bronchitis, tuberculosis, or emphysema . . . . . Yes No
   c. Other lung problems (please explain): ____
9. Do you have, or have you had the ***liver problems***?
   a. Hepatitis or yellow jaundice . . . . . . Yes No
   b. Other liver problems (please explain): ____
10. Do you have, or have you had ***kidney problems***?
    a. Frequent kidney infections . . . . . . Yes No

b. Frequent urinary tract infections or burning during urination . . Yes No
c. Frequent urination, or blood in the urine. . . . . Yes No
d. Other kidney problems (please explain): ______________________________

11. Do you have, or have you had ***stomach or intestinal problems***?
    a. Ulcers, blood in stool, black stools, or vomiting blood . . . Yes No
    b. Other stomach or intestinal problems (please explain): ______________________________
    ____
12. Do you have, or have you had ***blood problems***?
    a. Anemia . . . . Yes No
    b. Bleeding problems . . . . Yes No
    c. Bruise easily . . . . Yes No
13. Do you have or have you had ***endocrine problems***?
    a. Thyroid problems . . . . Yes No
       If yes, what type? ______________________________
    b. Cortisone or steroid treatments . . . . Yes No
    c. Pheochromocytoma . . . . Yes No
    d. Diabetes . . . . Yes No
    e. Hypoglycemia or low blood sugar. . . . . . Yes No
14. Stroke. If yes, when: ______________________________. Yes No
15. Fainting spells, seizures, or epilepsy . . . . . . Yes No
16. Have you been diagnosed with glaucoma? . . . . . . Yes No
17. Have you experienced tonsillitis? . . . . Yes No
18. Sinus trouble, hay fever, hives, or skin rash . . . . . . Yes No
19. Have you had, or do you have a serious viral illness? . . . . . Yes No
20. Arthritis or inflammatory rheumatism . . . . Yes No
21. Gout . . . . Yes No
22. Persistent cough or coughing up blood . . . . Yes No
23. Sexually transmitted disease. If yes, when treated ______________________________ Yes No
24. Do you have an autoimmune disorder . . . . Yes No
25. Have you had abnormal bleeding . . . . Yes No
26 Have you ever had any problem associated with tooth removal or other oral surgery . Yes No
27. Have you had any head, neck, or jaw injuries . . . . . . Yes No
28. Have you experienced any problems in your jaw, such as:
    a. Clicking, popping, or grinding . . . . Yes No
    b. Pain in the joint, ear, or side of face . . . . . . Yes No
    c. Difficulty opening or closing your mouth, or chewing . . . Yes No
29. List all surgeries and x-ray or radiation treatment for a tumor/cancer: ______________________________
    ____
30. Please list any other diseases, illnesses, or health problems not covered above: ______________________________
    ____
31. Please circle any of the following drugs you have taken in the last year: Aspirin
    Anticoagulants (blood thinners) Birth control pills Antidepressants
    Blood pressure medicine Cortisone (steroids) Tranquilizers or sedatives
    Insulin or diabetes drugs Digitalis, Nitroglycerin, or other heart medication
32. Have you **ever** taken/been given Bisphosphonates (these drugs are used to treat osteoporosis and some cancers) including Aredia, Zometa, Boniva, Fosamax , Actonel, alendronate, ibandronate, risedronate, pamidronate, or zoledronic acid. Yes No
33. List all medications (and the dosages) and herbal substances that you are currently taking: ______________________________
    ____
    ____
    ____
34. List all medications (and the dosages) that you have taken within the past 12 months but are not now taking:
    ____
    ____
35. Are you allergic to or have you had a bad reaction to any of the following:

a. Local anesthetics	Yes	No	g. Penicillin or other antibiotics.	Yes	No
b. Aspirin	Yes	No	h. Ketamine	Yes	No
c. Iodine	Yes	No	i. Codeine or other narcotics	Yes	No
d. Sulfa drugs	Yes	No	j. Pain medication	Yes	No
e. Steroids	Yes	No	k. Fentanyl, Demerol, or Brevital	Yes	No
f. Versed or Valium	Yes	No	l. Latex or rubber products	Yes	No

36. Do you have, or have you had any other ***allergies, including allergies to medicines or drugs***? Yes No
If yes, please explain: ______________________________
____

37. Do you now or have you ever smoked? . . . . . . Yes No
If yes, do you smoke now? . . . . . . Yes No
If you quit smoking, when did you quit? ______________________________
How many years have you or did you smoke? ______________________________
How many packs per day do you or did you smoke on average? ______________________________

38. Do you drink alcohol? . . . . Yes No
How much per day? ______________________________
How many years? ______________________________

39. Have you ever used illicit drugs? . . . . . . Yes No
If yes, which ones? ______________________________

40. Do you wear contact lenses? . . . . Yes No

41. Do you wear removable dental appliances? . . . . . Yes No

42. ***Women:*** Are you pregnant, or is there any chance that you might you be pregnant? . Yes No

43. ***Women:*** Are you nursing? . . . . Yes No

44. Do you wish to talk about anything privately with the doctor? . . . Yes No

45. Is there anything else you wish to tell us including further explanation of anything above? Yes No
____
____
____

I certify that I have read and understand the above. I will not hold my oral and maxillofacial surgeon, or any member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ ______________________________
Signature of Patient, Parent or Guardian *Date*

______________________________ ______________________________
Signature of Doctor *Date*

Update (subsequent visits only)

I certify that I have reviewed the above medical history.

❒ There have been no changes since the above date.

❒ Please note the following changes in my medical history.______________________________
____
____

______________________________ ______________________________
Signature of Patient, Parent or Guardian *Date*

______________________________ ______________________________
Signature of Doctor *Date*